VOLUME 57 • NUMBER 5 • MAY, 1961

**BOARD OF PUBLICATION**

Robert W. Kimbro, M. D., Cleburne
Chairman
Elliott Mendenhall, M.D., Dallas
Byron P. York, M. D., Houston
Troy A. Shafer, M.D., Harlingen
J. B. Copeland, M D., San Antonio
Charles P. Hardwicke, M.D., Austin
C. E. Willingham, M.D., Tyler

•

Harvey Renger, M.D., Hallettsville
President

•

**EDITORIAL AND BUSINESS OFFICES**

**1801 North Lamar Blvd., Austin**
**Telephone: GReenwood 7-6704**

C. Lincoln Williston, Executive Secretary
Ruth Trahan, Managing Editor
Marilyn Baker, Assistant Editor
Rae Murphey, Assistant Editor
Sue McBee, Editorial Assistant
Helen Miles, Secretary
E. Maxwell Jones, Business Manager
Sherman C. Roberts,
Advertising Manager

•

**PRINTING OFFICES**
**c/o Stafford-Lowdon Company**
**1114 West Daggett, Fort Worth 1**

•

Subscriptions: $3 per year for members;
$6 for nonmembers; $7 for foreign.
Single copy: 75 cents.

Copyright 1961 by the Texas Medical
Association. Owned and issued
monthly by the Association.

# Medical Care for Aged

*Fact or Fiction?*

On the following page appears a letter regarding medical care for the aged recently inserted into the *Congressional Record* by Senator Ralph Yarborough.

This letter, and unfavorable news stories based upon the case from Gonzales, Texas, that originated from Washington and were printed in several Texas newspapers caused Texas Medical Association President, Dr. Harvey Renger of neighboring Hallettsville, to investigate fully the facts in the case. Following are excerpts from a letter he wrote Senator Yarborough:

"The letter and the news articles contain many errors and misstatements. We are very sorry that the facts of the case were not investigated and verified prior to the letter's being inserted in the *Congressional Record* and released to Texas newspapers. The newspaper articles also indicate that you have brought this case to the attention of your colleagues in the United States Senate.

". . . I know that you are an individual of high ideals and integrity, and I feel certain that you will want to rectify this gross misrepresentation. As it now stands, the citation in the *Congressional Record* and the newspaper articles reflect most unfairly on many individuals in . . . Gonzales. It also is a reflection upon the medical profession and the Holmes Memorial Hospital in Gonzales, which have been serving the residents of the area for many, many years, and which have been caring for the needs of patients, regardless of ability to pay.

"You will find attached a full statement on this case. [Ed. Note: Copies of this fuller report are available from

Texas Medical Association headquarters upon request.] Permit me to comment on a few points made by Mr. A. L. Thomas, as published in the *Congressional Record* and in Texas newspapers:

"1. Mr. Thomas wrote: 'It is anticipated that she [the patient] will die quickly and be out of her misery.' Fact: The patient is making a nice recovery; her medical condition never has been termed as critical by the attending physician.

"2. Mr. Thomas implies that the patient has been grossly neglected, and has been denied medical and hospital care. Fact: Personal investigation has assured me that the patient has received good medical care.

"3. The news article appearing in the press (see attached clipping, *The Austin Statesman,* dated May 2, 1961, Washington) states that the patient who was burned more than a month ago still has not been hospitalized. Fact: The patient was admitted to the Gonzales hospital on March 30, and she remained through April 4. She left the hospital at that time at her own insistence. You will note that our investigation reveals that the patient declined to call a doctor for 9 days following the burn.

"4. Mr. Thomas writes that the patient was sent home 'to the shack, with no food, no medicine, not even an aspirin, and [the doctor] said she was all right." Fact: The patient received tetanus, antibiotics, and sedatives, and her burns were bandaged. She also was treated, as the report indicates, in the hospital, and in the physician's office.

"5. Mr. Thomas writes: 'The medical doctor's union (AMA) is not about to treat poor folks for free.' Fact: The doctors of Gonzales County, of Texas and of the United States have been rendering medical services for years to patients who have been unable to pay for their services. As evidence that this still is true, may I cite point 2 of the 10-point statement on Health Care of the Aged adopted by the House of Delegates of the Texas Medical Association at our 94th Annual Session in Galveston last week:

" '*Role of Physician.* The physician, by tradition, has a responsibility to provide professional services to his patients, regardless of ability to pay. Physicians will continue, as they have in the past, to provide medical services for the aged, including the indigent and the near needy, at fees they can afford, or without charge, as their resources might indicate.'

"In this connection, Senator Yarborough, I believe that you will be interested in the results of a recent survey of the 8,400 members of our voluntary Texas Medical Associ-

**GUS THOMAS INSURANCE AGENCY**

Gonzales, Texas
April 26, 1961

Re medical aid for the aged.
U. S. Senator Ralph Yarborough
Washington, D. C.

Dear Senator Yarborough:

Please use the following true story . . . in the battle to put medical care for the aged in our social security system.

An elderly couple have been living near Gonzales, in utter poverty. A neighbor lady noted the other day that she had not seen them lately, so she went over to check on them.

She found the lady had been burned terribly several days earlier, and was just laying there suffering. She and her husband got her to town to the county doctor. He treated her and quickly used up the old man's $69, and sent her home to the shack, with no food, no medicine, not even an aspirin, and said she was all right.

The neighbor persuaded another doctor to look at the old lady; he threw up his hands, said she was dying and needed to be in a first-class hospital, such as at Galveston. He treated her, and is having her bandages changed daily, per the report.

The neighbors have gone to the county authorities, the Red Cross, the welfare, without getting any aid for the burned woman. Now, the neighbors are poor people too; they are feeding the couple, but they can't help the old woman in her misery. It is anticipated that she will die quickly and be out of her misery.

I make a few points for medical aid for the aged through social security. Charity will not get the job done; 51 per cent of our citizens over 50 years of age are doing without medical care; the medical doctor's union (AMA) is not about to treat poor folks for free; we are spending untold millions of dollars treating previous members of the services for non-service-connected ailments; we are pouring untold millions into foreign aid, without buying one friend; we are running second in more than just space development. Time is running out.

Sincerely,
A. L. (GUS) THOMAS

ation. The survey revealed that the Texas physician is working an average of 60½ hours per week. He devotes an average of 7⅔ hours to free medical care to patients who are indigent, and to those who are unable to pay for their services.

"6. Mr. Thomas writes: 'Please use the following true story . . . in the battle to put medical aid for the aged in our social security system.' Fact: Investigation reveals that the patient is not a participant in Social Security. Even if the King-Anderson bill had been enacted by Congress and implemented, the patient would not have been eligible for medical care under the provisions of the program."

It is to be hoped that Senator Yarborough will rectify the misrepresentations contained in Mr. Thomas' letter by including all of the facts revealed by Dr. Renger's investigation in the *Congressional Record.*

## A Look at Education

Today, the physician is interested, as is every citizen, in assuring that the nation's youth receive the best possible education to prepare them for life. Second, he is interested in health education. Third, he is anxious that high school education prepare a larger number of the more able students for a career in medicine and allied professions. Fourth, he believes that education can preserve the American way of life and can stop the nation's drift toward socialism.

American youth has access to the best educational system in the world, even though some groups, disparaging this system, would completely revamp it along the lines of the Russian system. There is a moral responsibility in education. Granted that the burden of responsibility for the moral and spiritual development of the student rests with the parents. This does not, however, free the school from its obligation of maintaining an environment in which such moral and spiritual growth finds a healthy intellectual soil. In this area of difference between the philosophy of education held in America and that practiced behind the Iron Curtain is found the mustard seed of faith, which, if nurtured, blossoms into an expression of moral strength. Unless our system of education builds in youth the capacity to appreciate the creative fruits of other than material things in life, adults of tomorrow will be denied most of life's profound satisfactions.

A criticism of the present system of education is that since this country is dedicated to the principle of education for all, a hazard in the application of this ideal is overemphasis of the average. The solution of this problem must lie in the acceptance of the fact that the scholar possess qualities of individuality which cannot be frozen in an average mold without serious effects. During the early school years negligence of the bright students may lead to irreparable intellectual damage characterized by two closely related symptoms—mental laziness and loss of initiative.

Parents must not neglect their educational responsibilities with the expectation that the school will assume the entire burden. A Chinese proverb states that the mother as a teacher is the equivalent of a hundred school masters.

The present trend of making provision for exceptionally bright students is good, and probably will be expanded. The question of whether an exceedingly bright student should be advanced a year (skip a grade) has been debated for several decades. The present practice of allowing a bright student to progress beyond his peers in certain fields seems acceptable. The student who has exceptional capabilities in science or mathematics may remain in the same class while he takes advanced science or mathematics courses in a higher grade. This does not disrupt the whole school system, and it does not take him into a completely new environment.

*Health Education.* Health education involves formal health instruction, coordination and in-

tegration of health learning and experience, counseling and guidance, physical education, and recreation. It also involves the recognition that the full potential of health education can be realized only when efforts of the school, home, and community are inter-related. Members of the medical profession believe that health education should receive more emphasis than it does in many places. In some schools, the physical education department is responsible for teaching health education, and in the minds of too many people, health education simply means physical education. The importance of physical education should not be minimized, but it is only one part of health education in the public school curriculum. It affords a fine opportunity for teaching health.

*Medical Careers.* Members of the medical profession have a special interest in seeing that more high school students are prepared to enter college with an interest in studying medicine, nursing, laboratory technology, or other paramedical professions. Medical educators of today are of the opinion that a broad, general, cultural program in high school is the best training for premedical and medical studies. Study of languages—especially our own—should be emphasized. Unusually good students may be so poorly trained in the language arts that they cannot communicate well; thus, many of them have failed to pass medical college admission tests. Contrary to common opinion, medical college applicants are not required to have an "A" average for admission to medical college. About 60 per cent of such students at present have a "B" average.

The prospective medical student should have a well disciplined mind, wide human interests, and an intelligence able to move with the progress of human knowledge. The medical, engineering, and legal professions, and others, will be competing for this type of talent. A regrettable fact is that many of the most talented students never get to college—sometimes because of lack of money, sometimes because of lack of interest. Our educational system should be reconstructed to interest able students so that a larger number will have the plan, drive, and expectation of completing college. Many scholarship and loan programs are available. Notable examples are the American Medical Association scholarship plan; the Texas Medical Association's loan plan, which can provide financial assistance to as many as 80 students a year; and the Nueces County Medical Society's $1,000 scholarship.

A prime example of a way in which young people's minds can be challenged by representatives of science and industry is the Joe Berg Foundation program. At meetings which are held one night a week in about 400 communities over the nation, doctors, dentists, agronomists, chemists, engineers, mathematicians, social scientists, and other specialists give two hour lectures.

*Fighting Socialism.* The lure of federal aid to education should be offset by supplying the correct information that endorsement of this principle is a further step toward a socialistic nation. The integrity of the United States as a nation and the rights and dignity of man should be emphasized by educators. An attempt should be made to instill in oncoming men and women the courage to fight for these rights, rather than to sacrifice everything for a hand-out from a so-called benevolent central government.

Youth can be molded into a subservient people, or they can learn and practice the rugged principles that made our nation strong.

—JAY J. JOHNS, M.D., Taylor, Texas.

*Ed. Note: This editorial is based upon an address Dr. Johns gave before the Texas Education Agency on December 20, 1960. Dr. Johns is the Texas Medical Association's Adviser to the State Board of Education, and a member of the Association's Committee on School Health.*

## Transfusion Study Urged

The Joint Commission on Accreditation of Hospitals is citing the need—on the local hospital level—for an educational program to review blood transfusion practices. This, the

Commission notes, should concern not only those physicians interested in blood banking but all who prescribe transfusion therapy.

Although the Commission does not require their adoption, it endorses the following four recommendations made by the Joint Blood Council, Inc., whose members are the American Medical Association, American Hospital Association, American National Red Cross, American Society of Clinical Pathologists, and American Association of Blood Banks:

1. That each hospital institute a review of all transfusions of blood and blood derivatives by an existing committee of its medical staff or a separate transfusion committee.

2. That it be the committee's responsibility to make recommendations to the medical staff concerning the proper use of blood and blood derivatives in the institution. Formulation of policies should be consistent with good medical practice. The committee should be guided by the standards of the Joint Blood Council, the American Association of Blood Banks, and other authorities. The hospital pathologist should be a member of the review committee, and all clinical services should be represented.

3. That there be adequate procedures for identification and compatibility testing of blood in the hospital under the immediate supervision of a physician, and that these procedures be made a matter of record with the transfusion committee of the medical staff.

4. That this committee review all transfusion reactions occurring in the hospital, investigate completely possible causes of such reactions, and, on the basis of these investigations, make recommendations to the medical staff, if necessary, for improvement of blood transfusion practice.

## Backstage at Annual Session

From Friday, April 21, through Tuesday, April 24, Texas Medical Association officers, members of the local Galveston committees, and the Central Headquarters staff were catapulted through meetings, crises, and just plain hard labor to produce what was hoped to be a smooth-running and enlightening program for members and guests attending *Annual Session, 1961.*

Planning for the Galveston meeting actually began in 1959 when the isle was selected as the site for the session, but the major portion of the work has been concentrated in the past year. In fact, the Council on Annual Session will begin work May 20-21, to plan the 1962 fete, scheduled May 12-15 in Austin.

Preparation for each meeting is extremely detailed, including specification sheets which call for fresh water glasses and pitchers in each meeting room at a given time. Number of chairs and the direction which they are to face also is noted. Electrical outlets must be checked to allow for copying machines.

To ready a meeting worthwhile to Texas doctors, volumes of printing and mail are reproduced and sent from the Central Office. Each hotel room must at some time be inspected to determine its meeting possibilities. Rooms must be assigned and coordinated with all other meetings—time, location, and preferences of committee chairmen are considered.

Letters, thousands of them, are required to negotiate with guest speakers, with hotels, with exhibitors—both scientific and technical—and with committee chairmen.

Two days before the big meeting, a large semi-trailer truck pulls up to the headquarters building and loads heavy equipment for transport to the meeting location; one day later a truck loads boxes of stenographic supplies, reproducing machines, and typewriters, without which a meeting could not be held.

Then, it begins. Section meetings, exhibits, refresher courses, committee, board, and council meetings must be coordinated and supplied with equipment and information. The pace is tremendous and it is the duty of persons working behind the clockwork of Annual Session to keep it running smoothly.

# *By Any Other Name*

Following are reasons why I believe the Health Insurance Benefits Act of 1961 (King-Anderson Bill, HR 4222) is socialized medicine.

1. It provides for social security payments for medical care of the aged through the Social Security Law, which by nature is irreversible and constantly expanding.

2. The Secretary of the Department of Health, Education, and Welfare would be authorized to pay any institution or agency which he determines is a hospital, skilled nursing facility, or home health agency.

3. It is compulsory health care--the citizen must pay the tax.

4. Government employees would dictate what drugs and treatment doctors could provide their patients.

5. Each definition of a "hospital," "skilled nursing facility," and "home health agency" ends with these or similar words: "meets such other condition of participation as the Secretary may find necessary."

6. The Federal hospital system could take care of those older than 65, if the Secretary determined that a federal hospital provided services to the public generally as a community hospital.

7. There is no protection in the bill for an individual's hospital record to be kept confidential and away from federal investigators.

8. The bill dictates the amount of hospitalization, nursing facility care, or home health agency care an individual can receive regardless of whether his illness requires more.

9. It limits the doctor's activity to what a nonmedical authority may declare as "reasonable cost," thus controlling the doctor by governmental regulation by the same token that hospital services are controlled.

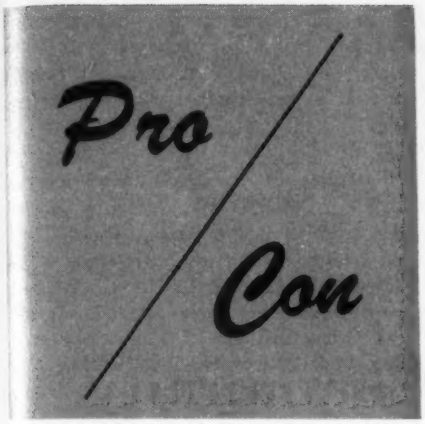
10. It taxes an individual for health care of the aged, but is deceptive in that it denies him full coverage. For each hospitalization period, for example, he must pay a deductible fee of $10 per day, with a maximum of $90 and a minimum of $20. The bill covers the services of only a few types of medical specialists.

11. The individual's freedom in choice of medical care is bound by governmental regulation.

12. Mr. Norman Thomas, head of the Socialist Party in America, is an advocate of this bill.

Harry Ruyon M.D.

President, Texas Medical Association




# What Price Football?

*A physician assesses junior high school athletics*

In January, 1961, the School Health Committee of the Travis County Medical Society learned that—without public notice or consultation from advisory health committees—contact sports (football) were being added as an elective extracurricular activity in the seventh and eighth grades of Austin public schools.

This decision was made by the Austin School Board, several members of which stated they knew nothing about the existence of advisory facilities.

The Society made a careful survey of available literature on the subject at once. Authorities in the field, both at the University of Texas and in the Austin school system, were consulted. The gathered material and opinions, together with voluminous literature obtained from the Texas Medical Association Library, resulted in a conclusion which has been made literally hundreds of times by others before: *contact sports have no place in the recommended health program for adolescent and pre-adolescent children.* The entire matter is extremely important in Austin, since its particular school system has, for all practical purposes, no physical education—nothing below the seventh grade or above the tenth, and very little in between.

With the collected information and upon the advice of its School Health Committee, the Travis County Medical Society asked the Austin School Board to (1) reconsider its contact sports program and (2) institute in the school system a full program of physical education to benefit *all* children of both sexes and in all grades.

The Austin School Board called a public meeting for further discussion of the program, a meeting which was well-attended by the general public and by medical society members. At the end of this meeting, however, the School Board announced that nothing would change its original decision. The sound recommendation of the medical society, plus the weight of public opinion, were scrapped. I believe the chief reason was that varsity coaches in local high schools need trained players to meet district competition.

Ten new teacher-coaches have now been employed, and a small percentage of Austin junior high school boys will get two weeks of training in preparation for later availability in the meat-grinding of district play.

The citizens of the community are paying the bill ($14,000 the first year, not counting coaches' salaries). The idea of an improved, expanded general physical education program has not been discussed publicly, nor, insofar as can be ascertained, considered.

This issue is not dead, however. Its revival will afford some persons in this city with an acute realization that democracy—at least in Austin—is still very much alive.

Perhaps other Texas medical societies might take a closer look at the contact sports programs in their own school systems—in behalf of the health of Texas school children.

—M. D. McCauley, M.D.,
Austin, Texas.

# Tuberculosis Case Finding

# A Community Demonstration

M. E. Malakoff, M.D., and
Arthur H. Dilly, M.S.A.

*The decrease in patient load at state supported tuberculosis hospitals is the result of inadequate case finding rather than a decrease in incidence of tuberculosis. Successful case finding techniques are reported.*

EARLY IN 1960 it became apparent that an unusual and disturbing situation was developing with regard to bed utilization in Texas' state supported hospitals for tuberculosis. These hospitals were operating with a 75 per cent patient load, whereas a few years ago waiting lists were the rule rather than the exception. It was obvious that this declining utilization of hospital space would result in a decreased budget allowance for future fiscal years, and thus would reduce patient facilities. For this reason, it seemed an opportune time to demonstrate that this decreased bed utilization was attributable to inadequate case finding programs, rather than to a decrease in the overall incidence of tuberculosis.

In February, March, April, and May, 1960, the Webb County Medical Society, Webb County Tuberculosis Association, Laredo-Webb County Health Department, Texas State Department of Health, Texas Tuberculosis Association, and H. E. Butt Foundation jointly sponsored a concentrated program to detect tuberculosis in Laredo.

This program consisted of two case finding procedures:

1. A tuberculin patch test for all school children whose parents would permit it, and;
2. A mass chest roentgenogram program for persons more than 15 years old, with emphasis on the following groups:
   a) Contacts of known tuberculosis patients.
   b) Adult members of families in which children had positive reactions to the skin patch test.
   c) Persons more than 50 years of age.

Laredo was selected for the detection program on the basis of its statistically demonstrated high incidence of tuberculosis. The new case rate per 100,000 population for 1959 would approximate 120, whereas the statewide average is about 45 new cases per year per 100,000 population. In addition, tuberculosis is known primarily to be a disease of the lower

socioeconomic groups, and of the Latin-American population. Laredo, with a low average household income and an 85 per cent Latin-American population, should have a considerable rate of tuberculosis.

## School Patch Testing Program

Of approximately 10,000 public school children, 8,599 were given patch tests. School health nurses read 1,023 positive results. This is a positive reaction rate of 11.9 per cent, as compared with a selected statewide average of approximately 3.5 per cent.

A total of 1,502 children in Catholic schools were permitted by their parents to be given patch tests. This resulted in 47 positive readings, or 3.1 per cent. The lower percentage of positive reactors among these students may be related to the fact that children in these schools are from a higher socioeconomic group, since Catholic schools charge tuition.

It was recognized that the patch test was not the screening procedure of choice. However, the method was utilized because it could be administered easily and was well accepted by the parents and students. Plans have been formulated to administer future tuberculin testing programs by the Heaf multiple puncture method.

Several other counties in the state undertook extensive tuberculin testing programs in 1959 or 1960, largely under the sponsorship and direction of local tuberculosis associations. The percentage of positive reactions from these programs, when compared with the Laredo results, show the latter to have a significantly greater percentage of positive reactions within the public school population.

TABLE 1.—*Comparative Results, Various County Wide Tuberculin Testing Programs.*

| County | No. Tests | Positive Reactions | % |
|---|---|---|---|
| Potter-Randall | 7,167* | 102 | 1.4 |
| Lubbock | 7,461† | 182 | 2.4 |
| El Paso | 30,809* | 2,064 | 6.7 |
| Laredo (Webb) | 8,599† | 1,023 | 11.9 |

*Mantoux test procedure.
†Patch test procedure.

The results shown in Table 1 indicate that an alarming number of children in the Laredo public schools have been, or are now, in contact with an active case of tuberculosis. Complete follow up procedures were necessary.

All children whose reactions were positive were encouraged to have roentgenographic follow up, either by a private physician or by the public health clinic. The complete results of these roentgenograms are not yet available, but tentative results show that several children were removed from school, and that additional diagnostic work is indicated for several more. The status of all of these children will be clarified and the results tabulated as soon as positive findings are known in all cases.

Armed with these results, the Laredo Independent School District trustees took immediate and forceful action. In order to obtain the full benefits from this tuberculosis screening program, and to insure adequate case follow up, they adopted the following policies:

1. Two school health nurses were retained during the summer months for follow up work.
2. A child with a positive patch test reaction was required to present proof of a negative chest roentgenogram for tuberculosis before readmission to school in September.
3. Any child who was not tested in the spring program was required to be tested, and the results made available to the school in September.
4. All children entering the Laredo public schools for the first time were required to submit evidence of a negative tuberculin test, or chest roentgenogram.
5. All school employees were required to have an annual blood serology and chest roentgenogram as a condition of continued employment.

There is no doubt that these new policies will have several far reaching and advantageous effects.

No child with active tuberculosis will be in the classroom.

A list of persons having positive reactions will facilitate periodic roentgenographic follow up, where indicated.

Periodic retesting of persons having negative reactions, with a reaction change from negative to positive within a limited period, is an excellent indication that a case of active tuberculosis exists within that child's immediate environment.

Emphasis on the importance of good tuberculosis control procedures in the schools will serve as an excellent educational medium in the home situation. A public awareness of the dangers of tuberculosis is the first step toward public acceptance of a continuing tuberculosis control program.

## Mass Roentgenographic Program

Two portable x-ray units from the State Health Department were used in Laredo for 8 weeks in both downtown and neighborhood locations. During this period a total of 17,280 roentgenograms were made. Of this number approximately 10 per cent, or 1,728, were made of Mexican residents, primarily from Nuevo Laredo. The 15,552 roentgenograms which were made of Webb County residents

were approximately 6,000 more than had been made in any other mass roentgenographic survey in that area.*

One of the groups which received special emphasis regarding roentgenograms was persons more than 50 years old. In Webb County this age group comprises 18 per cent of the total population.† During this survey, approximately 21 per cent of the persons screened were in this group. Since this older segment of the population, especially among Latin-Americans, is difficult to reach because of long acknowledged fears and superstitions, the aforementioned figures indicate reasonable success.

An effort was made to ascertain the number of contacts of known tuberculosis patients and the number of contacts of persons who had positive tuberculin test reactions. There were 3,626 adult household contacts located from the school patch testing program. In addition, 747 adult household contacts of known tuberculosis patients were recorded from the case register. This means that there were a total of 4,373 close household contacts of both persons with positive test reactions and known cases of tuberculosis. These persons were sent various letters and other material urging them to take advantage of the mass roentgenographic survey. Of these total contacts, 1,356, or approximately 32 per cent, had roentgenograms made. Of the latter total, 241 were contacts of known tuberculosis cases and 1,115 were

household contacts of persons having positive tuberculin reactions. In spite of the specific encouragement of this group to participate in the survey, a smaller percentage of them responded than did in the general public.

During this survey approximately 37.4 per cent of the population older than fifteen years was examined by roentgenogram. This is predicated on a 1960 census figure of 64,847 for Webb County, with an age distribution which indicates that 36 per cent of the population is younger than 15 years. Although the figure of 37.4 per cent of the eligible population screened by roentgenogram is not outstanding, it is a higher percentage than has been realized in previous surveys.

*It is recognized that some roentgenograms were made of residents of other Texas counties, and of other states, but the number is not of statistical significance.

†Age percentage breakdown based on 1960 Bureau of the Census preliminary reports for Webb County.

## Preliminary Results

The readings of the screening films are as follows:

TABLE 2.—*Results of Mass Roentgenographic Film Readings, Webb County Survey.*

| | |
|---|---|
| Tuberculous Disease: | |
| Suspicious | 157 |
| Minimal | 144 |
| Moderately advanced | 59 |
| Far advanced | 19 |
| Total | 379 |
| Nontuberculous Disease: | |
| Cardiac | 141 |
| Other | 16 |
| Total | 157 |
| Total Abnormalities, All Types | 536 |

The 379 cases of suspicious tuberculous disease, however, were not all located in Webb County. Eleven cases were from outside Webb County and 32 cases were among residents of Mexico. Of the remaining 336 persons having suspicious findings, 32 already were known to the local public health department. *This means that this tuberculosis detection survey uncovered 304 new suspicious cases of tuberculosis.*

These findings, when reduced to percentages, indicate that approximately 3.2 per cent of the films read on Webb County and other United States residents were abnormal in some degree. Significant also is the fact that 2.23 per cent of the total number of films read of United States residents revealed some tuberculous disease.‡ The most significant fact disclosed by this survey is that 2 per cent of the films

TABLE 3.—*Comparative Results, Various Community Mass Roentgenographic Surveys.*

| County | Total Roentgenograms | Suspicious TB | Other Disease | % TB |
|---|---|---|---|---|
| Laredo (Webb) | 15,552 | 347 | 157 | 2.23 |
| Galveston | 23,000 | 380 | 261 | 1.65 |
| Dallas* | 7,484 | 107 | 143 | 1.42 |
| Bexar | 27,454 | 312 | 284 | 1.13 |
| Houston (Harris) | 150,383 | 1,148 | 630 | .76 |

*This was in recognized areas of high incidence.

‡The exact number of screening films made on non-Webb County residents is not known. However, the number was very small and would not affect the statistical compilation to any marked degree.

taken of Webb County residents resulted in detection of suspicious cases of tuberculosis unknown to the health department. Once again, the percentages for Laredo are high when compared with mass roentgenographic programs carried on in other parts of the state by tuberculosis associations' mobile units.

The age groupings of the suspicious cases of tuberculosis discovered during this survey emphasize that tuberculosis is becoming a disease of older age groups. More than 50 per cent of the suspicious findings were in the over 50 age group (Table 4).

TABLE 4.—*Age Distribution, 379 Suspicious New Cases of Tuberculosis from Webb County Survey.*

| Age Group | % |
|---|---|
| 15-20 | 5.6 |
| 21-35 | 21.7 |
| 36-50 | 18.7 |
| Over 50 | 54.0 |

It is realized that only a small number of these 304 readings eventually will be diagnosed as new cases of tuberculosis. However, certain beneficial results of a such a survey, aside from actual discovery of new cases, are obvious.

The relatively high percentage of tuberculous abnormalities shown in the screening film readings indicates that Laredo is worthy of extensive case finding efforts.

Since previous mass surveys in Laredo and Webb County have resulted in 8,000 to 10,000 roentgenograms, the current program total of approximately 15,552 indicates that perhaps 5,000 people were included who had not had roentgenograms in recent years.

The publicity and the concern of the public school trustees have contributed to a greatly expanded community consciousness regarding tuberculosis.

The State Health Department reallocated salary funds to the Laredo-Webb County Health Department to operate a full time roentgenographic clinic.

The Texas Tuberculosis Association provided a clerk's salary for 6 months so that the local health unit may bring the tuberculosis case register up to date, and record the progress of the mass chest roentgenographic follow-up.

The H. E. Butt Foundation provided the services of a nurse for 6 months to assist the local health unit in the nursing follow up of mass survey results.

## Follow Up Results

Since the roentgenographic phase of the tuberculosis detection program was completed May 13, 1960, and follow up studies by private physicians and the Health Department were instituted, the number of new cases of tuberculosis reported from Webb County has increased remarkably. For comparative purposes, Table 5 outlines the reported tuberculosis cases for the past several years.

**Dr. M. E. Malakoff is in private practice in Laredo, and is a member of the Texas Medical Association's Committee on Public Health. Mr. Arthur H. Dilly is Hospital Consultant for the H. E. Butt Foundation in Austin.**

There has been an excellent cooperative follow up program in operation in Webb County since the end of the survey. More new cases of tuberculosis have been reported from Webb County in the last year than in any previous year since 1948, when an extensive survey was completed.

The follow up activities have not stopped with the clinical diagnosis. Exceptional effort has been put forth to hospitalize those persons with newly diagnosed cases of tuberculosis. From June 1 to December 31, 77 patients were admitted to the state tuberculosis hospitals from Webb County. Approximately 25 per cent of these patients had tuberculosis in a minimal stage when admitted. This rate is very high, compared with the fact that patients with minimal disease average only eight per cent of total admissions to state tuberculosis hospitals. Nearly all of the cases were discovered as a result of this community-centered tuberculosis detection program.

TABLE 5.—*Reported Tuberculosis Morbidity January 1, 1957, to December 31, 1960.*

| | Year | Deaths | |
|---|---|---|---|
| | 1957 | 39 | |
| | 1958 | 50 | |
| | 1959 | 75 | |
| Jan. 1-May 31 | 1960 | 41 | |
| June 1-Dec. 31 | 1960 | 135 | (Period of intensive follow up) |

In view of this demonstration, there seems to be little doubt that a full scale community program with emphasis on the accepted and recognized case finding methods paid enormous dividends in the Laredo area. At the same time, comparable community tuberculosis detection programs using the same techniques and procedures would be successful in areas with a high incidence rate of tuberculosis.

## Summary

The experience of this tuberculosis case finding program in Laredo emphasizes important conclusions.

1. A repetition of the successful case finding techniques utilized in Laredo in other known areas with high incidence rates of tuberculosis in the State would reveal large numbers of heretofore unknown, undiagnosed cases.

2. Adequate public health and community follow up procedures aimed at ultimate hospitalization of the new patient would once again fill the state supported tuberculosis hospitals to capacity.

3. It is time for Texas to find and hospitalize all new patients with tuberculosis possible, and to rehospitalize known patients with a current need for hospitalization. These two programs would end for some years the talk of curtailing beds for the hospitalization of the tuberculous.


Dr. Malakoff, 1515 Hendricks, Laredo.
Mr. Dilly, 307 Vaughn Bldg., Austin 1.

---

# This Problem Is a Stinger

A stinging caterpillar—megalopyge opercularis or plain old "wooly worm"—has become a public health problem in some southern states, notably Texas.

So says an article in a recent issue of *The Journal of the American Medical Association* written by Dr. John P. McGovern, Dr. Gilbert D. Barkin, and Reubin Wende, M.S., all of Houston, with Dr. Thomas R. McElhenney, Austin.

About 2,130 stings were reported during an epidemic in southeastern Texas in the summer of 1958. There is a pronounced increase in the prevalence of the caterpillars every 4 or 5 years, it adds.

The "wooly worm" in question has many quills which release a poison on contact. The sting can cause severe local pain, swelling at the site of the sting, headache, shock-like symptoms, and convulsions.

Although no deaths have been reported from the sting, the authors noted, the severity of symptoms in some patients suggests that death could result.

Texas apparently has the largest number of the caterpillars, but they also have been reported in Missouri, Maryland, Virginia, North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, and Louisiana.

# Effective Use of Ancillary Personnel

## In Rehabilitating The Mentally Ill

*A group of patients with chronic schizophrenia have been rehabilitated after continuous hospitalization for an average of six years. Utilization of ancillary personnel in creating a democratic, warm, hopeful atmosphere for therapeutic work is credited with great success.*

George W. Brooks, M.D.

DURING THE PAST six years, the Vermont State Hospital and the Vermont Vocational Rehabilitation Division have been successful in re-establishing a large number of long term patients in the community. This has been accomplished through a flexible and varied program of drug treatment and preparation within the hospital, and a variety of aftercare and transitional facilities. Three hundred eight patients have participated in this program for six months or longer. Of these, 203, or about 66 per cent, are now out of the hospital. Their average duration of continuous hospitalization before release was more than six years. Their average duration of illness was more than 12 years. The more chronically ill members of the group were released through the Vocational Rehabilitation Division's rehabilitation house. Not only have these patients remained out of the hospital, but when they were checked six months after leaving the institution, 75 per cent were fully self-supporting and another ten per cent partially self-supporting. The majority were in social settings that required or encouraged much social interaction. This sort of record with a group of such chronically ill patients seems to us quite remarkable.

### History

In attempting to assess the reasons for such success with patients who had chronic mental illness, the author has become interested in historical parallels to his experience. In 1887, Rorie[8] chided his colleagues about their preoccupation with new treatments for mental disorders. He asked them to remember that remarkable results were being achieved long before any of their new treatments had been developed. He was referring to the early experiences of the Dundee Royal Asylum, of which he was, at that time, superintendent. He stated, "We are accustomed to hear so much of the great improvements which have of late years been effected . . . it is to be feared that few nowadays realize the advance that had . . . been made . . . a number of years ago when patients were treated with 'great gentleness and considerable liberty and comfort.'" Rorie quoted from the annual reports of the Asylum in 1821, 1822, and 1825, as follows: The patients are "no longer condemned to drag out a miserable existence in filth. . . . The spirit of the times respects the feelings of the unhappy sufferer, [and] fans the latent spark of reason. . . . Several who had known

only chains and solitary confinement for many years experienced immunity from all restraints . . . and were enabled to join in the amusements and recreations."

Ninety-two of 96 patients were constantly employed one year after being transferred to the Asylum. "Some of the worst varieties of madness, with all its resulting accompaniments, have given way to use of active remedies, but experience justifies the remark that it is neither by an exclusive moral treatment nor the use of remedies alone . . . that . . . cure . . . is to be effected . . . but . . . by a happy combination of both." Then Rorie concludes, "Has there been any great change?" He explains that at the time when such remarkable results were being achieved with the most "difficult" patients, there was no attending physician at the hospital, no professional class of workers of any kind, but merely benevolent concern on the part of compassionate people who were endeavoring by the application of great "gentleness" to help their suffering fellow man.

Ozarin[7] points out the great period of enlightenment or moral treatment in mental hospitals, "Moral treatment was differentiated from medical treatment and was usually the responsibility of the lay officials in the hospital. Perhaps the fact that several generations of Tukes were laymen contributed to this practice. But Pinel had also recognized this dichotomy. He had observed at the Bicetre that the kindly, tactful, yet just and firm management of the patients by a remarkably able lay superintendent and his staff of disciplined attendants was apparently accomplishing more for their relief and cure than he was capable of with all his learning and resources as a physician."

The author discovered these historical parallels after most of his work was completed. Otherwise, it might not have taken him so long to discover that not only was it necessary to give lip service to the fact that the ancillary workers such as occupational therapists, attendants, work supervisors, or nurses were important to the patient, but also that physicians should conduct themselves in accordance with this basic fact.

## Staff and Equipment

Through the present project for the rehabilitation of chronic schizophrenic patients, it has been learned that it is not necessary to acquire large sums of money nor greatly to implement the institution's staff with professional personnel in order to demonstrate good results. The existing staff, with but few additions, utilizing equipment on hand can do effective work. A staff once devoted to custodial and traditional patterns of patient care can give humanitarian and therapeutic service. What has been true in the author's hospital can be true in most state hospitals. Similarities with other mental institutions in the country are far greater than differences. Success in the present instance may give hope to those institutions which desire to undertake rehabilitation work but are blocked by the assumption that it takes a lot of money and trained personnel.

## Type of Patients

Following is a brief description of the patients and of the author's work with them. In the rehabilitation of these patients, the three areas of disability which the patients needed to overcome were considered. The first relates specifically to intellectual function. These patients are slow, concentrate poorly, seem confused, and have impairment of memory. They also have a group of disabilities related to their extreme sensitivity and the intensity of their momentary emotional reactions. They are touchy, suspicious, temperamental, unpredictable, and over dependent. In addition, there is a whole area of disability related to the constriction of their world and their perception of it. This causes them to develop peculiarities of appearance, speech, and behavior, and to have a constricted sense of time, space, and other things so that their social judgment is inadequate. They seem without goals, or have fantastic goals, and lack initiative or concern about what is beyond their immediate surroundings. In addition to these secondary disabilities, most patients come from a low socioeconomic level and suffer from profound poverty, inadequate educational opportunities, and a limited experience in the world.

The aforementioned disabilities are present in many schizophrenic patients even after brief hospitalization; they are much intensified after prolonged hospitalization. Other disabilities are added by the ever widening gap between the patients' culture and the culture of the world outside the hospital. There are gross differences between a total institution and a democratic society. These have best been described by Goffman[4] in a series of articles. Other gross differences result from a different cultural clock in the institution and in society. Rapid and extensive changes in almost every aspect of living have been taking place since the day, perhaps many years ago, when the patient was admitted. Patients must be acquainted with technical changes, economic changes, and changes in the general pattern of values.

In addition to the major disabilities of the long term schizophrenic patient, there are various elements in the background which help to explain his

motives. These background elements can be considered roughly in terms of psychopathology or dynamic aspects of illness, sociopathology or group dynamic aspects of the present situation, and the physiopathology or physical aspects of deterioration.

A rough and ready, dynamic definition of schizophrenia might be a reaction in which a patient's ego cannot mediate between id and reality pressures. In such an oversimplified scheme, schizophrenia might develop when reality pressures are too great or id pressures are too great, or when the ego is too weak and disorganized to mediate between the two. In most cases, there are elements of all three factors. Most schizophrenic patients have a long history of severe environmental trauma. Frequently this extends back to such an early age that powerful and uncontrollable id conflicts have been inevitable. In addition, there frequently is evidence of a familial or perhaps congenital weakness of potential ego development. Of course, it is not yet known whether this is related to a basic defect in central nervous system metabolism. In many cases, it seems more like a defect in the education of the individual. He may not have been taught to cope with reality or may even have been taught to deny it.

The total effect of this combination of disintegrating factors in the patient is to produce a sense of impending dissolution of the personality. This leads to an extreme sense of panic, terror, and horror, as outlined by Sullivan.[10]

## Social Environment

The social setting of the patient who is hard to reach has been best characterized, as noted above, by Goffman,[4] who points out that the inmate in the total institution usually has been denied most opportunities to communicate effectively with those in charge of his future. Attendants and other ancillary personnel have suffered a similar denial, as noted by Bockoven.[2] He states, "It is the attendant who occupies the most difficult and frustrating position. He serves as guard and taskmaster whose duty it is to preserve order by restricting patients' spontaneous movements to a mimimum and by closely supervising any duty he directs the patient to perform. He is the most important person in the patient's life, but his position in the hospital hierarchy is of the lowest order. He is subjected to a rigid discipline which requires him to maintain an impersonal relationship with patients and holds him responsible for any mishap which occurs. He must constantly be on the lookout lest some patient acquire a bit of glass, a length of rope, a sliver of wood or a supply of matches; for every patient is suspect of harboring violent tendencies or desires to escape. He must even restrict conversation between patients lest altercations result. He is fulfilling his duties well if he is observed to be presiding over a scene of somber silence when the supervisor, nurse or physician 'trips' through his ward. All told, his task is a thankless one, for like the patient he remains in good standing only so long as there are no mishaps. There is no way he can progress or better himself. At best, his only prospect is the endless monotony of an uneventful life on a 'well-managed' ward. His very acceptance of the low pay bespeaks in his own mind and in the minds of others that his work is little respected. And in the public mind his very capacity to endure close association with the fancied depravity of the mentally ill places him in a category as uniquely stigmatized as that of mental illness itself."

## Physical Incapacities

The physical incapacities exhibited by long term patients are both specific and general. Specifically, the patients' psychomotor performance in a wide variety of tests is impaired so that their reaction times are prolonged and their ability to perform skilled or precise activity is impaired.[6] Generally, they suffer an increased incidence of degenerative and chronic diseases, as noted by Appel[1] and others, including tuberculosis and malignant tumors. There is a high incidence of needs in such areas as dental care, visual corrections, and hearing aids. Many patients, especially after prolonged phenothiazine treatment, are obese. Care of the feet usually has been neglected. In the author's experience, there also seems to be a high incidence in chronic skin disorders including eczema, dermatitis, tinea, and psoriasis.

## Treatment and Rehabilitation

The psychic, social, and physical backgrounds of these patients' disabilities have been outlined. The problem is to design comprehensive treatment and rehabilitation methods. Specific measures should be directed toward the background of the disability. Relief of the psychopathology is directed first at the reality problems, second at the ego problem, and third at the disintegrating unconscious pressures. Relief of reality problems in acute schizophrenia usually begins with hospitalization. This alone often reduces reality pressures to a point at which the patient's ego can cope with the situation. Much of any remotivation program must be directed toward making the environment of the patient as free from unnecessary discomfort as possible. Pleasant living

arrangements, clothing, and food are essential. Interesting, stimulating surroundings, restricted enough to be within the familiar range of the patient's background, are essential.

Efforts to give the patient as much increase in his ego strength as is consistent with his basic intelligence and background are essential. This "educational therapy" includes every variety of educational activity. The damage done by long years of hospitalization must be undone. Therapeutic activities should be designed to re-educate the patient in his social relationships, and to educate him in the complex areas of modern community living such as political, economic, and technical changes. Usually, the patient will be hungry for information in addition to that available on television and in the daily newspaper. He should be given a chance to hear lectures by recognized leaders in as many fields as possible. He should be informed about international affairs, and should be given every opportunity to improve his appreciation of the arts.

Last, efforts must be made to reduce the disabling id conflicts which the patient may have had since an early age. In the average mental hospital, this is best accomplished by permitting many opportunities for corrective emotional experiences. Most such experiences are dependent on the parental function of attendants, work supervisors, and other ancillary personnel. Patients who have never known anything but rejection by significant parent figures slowly and painfully learn that there are people on whom they can depend. This may be a frightening experience for them, and it requires a great deal of courage. The associated anxiety is reduced by the multiplicity of the parenteral figures provided in a social psychiatric program.

The intensity of responsibility which this phenomenon places on the therapeutic figures in the patient's life is also somewhat reduced by the multiplicity of parent figures, but constant efforts to support attendants and houseparents must be made. These dedicated people may overextend themselves; some attendants, for example, return to the hospital in the evenings or stay one or two hours after the work day is over. The sociologist may be working seven nights a week. Houseparents, whose job potentially is a 24 hour one, may fall into the habit of actually working almost 24 hours without vacation periods. Vocational counselors find calls on their services every Saturday and Sunday. If such a work schedule is allowed to continue, the victim may suffer a subtle transformation into a relationship almost typical of that of a schizophrenic's parent, becoming overly possessive, protecting, and pathologically identified with his charges.

Provision of a sincerely homelike atmosphere, a stimulating and strengthening re-educational and educational program, and a series of corrective emotional experiences with parent surrogate figures are the essentials of a program for patients who are hard to reach.

The sense of impending dissolution of the personality, which accompanies fragmentation of the ego in schizophrenic patients, usually is accompanied by a deep seated sense of panic, overwhelming fear, or dread. Fear is a disabling influence which motivates the patient to avoid as many new, strange, or challenging situations as possible. Release of the patient's motives for further growth and development depends on the degree to which panic can be relieved. It is relieved to some extent by a kind, accepting, tolerant, permissive, but supporting and guiding social psychiatric program, as in Dundee more than a century ago. However, in the majority of cases, it is necessary to use tranquilizing medications before further progress can be made. In the author's experience, 9 of 10 patients with successful results have had long term neuroleptic treatment, and are continuing such treatment after rehabilitation.

## Drug Therapy

The necessity for drug treatment sometimes complicates the patient's slowness of reaction and performance. The frequent occurrence of symptoms of extrapyramidal dysfunction usually is associated with some psychomotor impairment. The patient's drug treatment must be so balanced and controlled that secondary disability is minimal. This sometimes is a long, delicate process, which has resulted in the use of a variety of dosage regimens of both tranquilizers and anti-Parkinsonism drugs in an attempt to individualize the dose to achieve optimal control of panic with minimal psychomotor impairment.

## Educational Therapy

Much of the educational therapy centers in an activity program, which must be designed with the patient's basic disease and secondary disabilities in mind. Activities which will be meaningful to chronic schizophrenic patients must provide a fairly early and concrete gratification because of the narrow time and space perception of these patients. Gratifications which seem to appeal most readily to the regressed patient with schizophrenia are oral and anal, as pointed out by Sechehaye[9] and Wittkower.[11] Activities which promise these gratifications should be realistic and meaningful to the patient's immediate situation. Because of the patient's desocialization,

such activities are best carried out in a situation which encourages or requires group cooperation. Furnishing money, a means of oral gratification and a symbol of anal gratification, is the next step. For gratifying activities to have meaning in terms of progress toward a more self sufficient mode of existence, they must include opportunities for re-education that will close the gap between the patients' culture and that of the world outside.

A group project to prepare, serve, and eat a meal fills most or all basic needs. The reward for this activity is immediate and provides oral gratification, plus the necessity to read directions on foodstuffs, use modern kitchen equipment, and make a pleasant and proper table setting. All this tends to re-educate, to provide more interesting and varied menus than the usual hospital fare, and to relieve the patient's feeling of poverty. The obvious pleasure which all of these activities afford provides a vehicle for expression of sincere interest and attention of the staff. Group work with clay, particularly with hand molded clay objects, provides a similar setting of resocializing and re-educating activities with obvious gratification and an early reward of a concrete nature if the patients can keep things they make. As patients progress toward more highly socialized and efficient activities, so that they can visit and shop in the local community, money should be given them as a direct reward for their progress and because it provides symbolic anal gratifications which are common to their culture.

The gap between the culture in a total institution and a democratic society can only be filled by changes in the total institution or the democratic society. Unless we wish to make the society totalitarian, the institution must be democratized. This requires an effort to involve attendants and patients in decision making, and to use their invaluable knowledge about the day to day operation of the hospital. The form of this effort is not as important as that it be sincere, realistic, and meaningful. A patient government which has no real power is no government; a ward meeting at which decisions are made for attendants instead of by and with attendants is useless.

Bringing the patients up to date is a long, slow, detailed, painful, and infinitely complex process. The uninitiated could never imagine how thoroughly outdated are the patient's experiences. Some patients never have ridden in a vehicle with an internal combustion engine, unless a hay burner is considered as such. Many patients have had no experience with traffic, traffic lights, and warning signs. Patients incarcerated only a few years frequently are totally out of touch with prices and current living expenses. Many have had no experience with the modern textiles, as the hospital laundry is best suited for cottons. Some activities seem to have been forgotten, such as ordering and eating meals in restaurants, buying tickets for a trip, or reading a time table. Some patients with a basic education and average intelligence have difficulty making change or checking on their change when making a purchase.

The problem of providing constant guidance, education, and of providing gratifications sometimes is very trying. A fairly frequent phenomenon is a repeated adolescent rebellion in which patients severely test the limits of new privileges. They go on spending sprees; buy on a time payment plan, which is strictly against the rules; give their money freely and foolishly to other patients who do not know how to use it; engage in multitudes of minor mischief such as breaking smoking rules, abusing privileges, and so forth. They bring long lists of picayune demands for new comforts and luxuries on the wards. As in so many in comparable stages of development, patients seem to have an inadequate sense of gratitude. These things require the patience and understanding of mature personalities. They also require support and guidance for the attendant personnel by the professional staff.

## Democratic Surroundings

The social setting of efficient psychiatric hospital treatment for these disorders must be democratic in the sense that not only are its members permitted to express their opinions and participate in decision making, but they are encouraged and expected to do so. The author's studies have indicated that effective teamwork in the rehabilitation of long term patients who are hard to reach requires as much time for the team members to work with each other as for them to work with patients. Also, the achievement of effective team work requires hard labor and the constant renewal of one's commitment to a respect for the opinions, knowledge, and deeds of others.

This gives rise to what at first seems a paradox. It is essential that most communications in such a democratic operation go "through channels"; in other

words, one does not avoid working out a situation with one's colleague or immediate superior by going over his head to someone with greater authority. In this sense, the operation of a therapeutic community, within the framework of a traditional authoritarian institution, presents some advantages. The democratic process is enhanced by the presence of an established structure which clearly defines the channels between, and relative relationships among, the various personnel.[3]

Thus, comprehensive programs of patient care must be designed and effected which, through teamwork in a democratic institution, will permit the available personnel to (1) ameliorate the reality problems of the patient; (2) educate, train, and strengthen his ego; and (3) work out his intense inner conflicts with parent figures. All this must be done by techniques with which the disabled patient can cope, but this is not enough. Even though symptoms of his disease may be relieved and his disabilities compensated for, the patient remains partially disabled. He still is somewhat slow, sensitive, constricted, and dependent. Successful rehabilitation will depend on continuity of relationship and support. Medication to dull the edge of his mental anguish may be needed for many years. A system must be set up to insure continued contact with familiar figures. Personnel, such as vocational counselors, halfway house parents, and social workers, must have come to know the patient some time before his release from the hospital. Hospital personnel should continue to keep in touch with patients by seeing them when they revisit the hospital, or by attending social functions outside the hospital, staffing aftercare clinics, corresponding, publishing news sheets, and so forth. The environmental comforts, ego strengths, and id tranquility so carefully established in the hospital program must not be allowed to collapse by sudden and cruel abandonment after release.

## Therapeutic Atmosphere

In addition to measures directed at the basic psychosocial disability of the chronic schizophrenic patient and the therapeutic efforts which must be directed at the sources of his inner tension, the overall atmosphere in which these activities occur must be considered. All of these factors require real, meaningful contacts with the patient. To develop such rapport with an extremely frightened, sensitive, and suspicious patient requires the utmost in sincerity and commitment. Continuation of these activities will depend on the integrity of a contract between the therapeutic personnel and the patient which implies, in essence, "We want you to want to do these things for your own sake and for the sake of your growth and development," rather than any suggestion that "We want you to do this to please us," or "We want you to get well because we don't like you the way you are," or similar false contracts. Without minimal sense of continuing and relatively permanent commitment on the part of patients and staff, none of these activities can be fruitful.

**Dr. George W. Brooks of Waterbury, Vt., who is Director of Research at the Vermont State Hospital, presented this paper at the Institute on Rehabilitation meeting September 23, 1960, in Austin.**

In addition to this sense of trust or commitment, patients must be able to see in their own frame of reference some realistic goals for their efforts. Patients frequently have said, "Why should we get well? Nobody wants us. There is no place for us to go. We won't have any job. Where will we sleep? What will we eat?" Until they can see that there actually is a home where they can go and a job they can do, they feel, justifiably, that they are better off in the hospital. In the program of the author's institution, this realistic goal has been provided by the services of the Vocational Rehabilitation Division, which offers patients financial assistance, job training, transitional support and, if necessary, a rehabilitation house or other adequate living arrangement. Such tangible goals, plus constant information about the successful transitions of fellow patients, keep a high level of optimism among both patients and staff.

In addition to commitment and optimism, patients must feel that there is real compassion for them by those who are working with them. Staff members who do not like or do not feel comfortable with schizophrenic patients cannot do this work. However, there are large numbers of staff personnel in mental hospitals who have stayed many years primarily because of their compassion for this type of patient, and certainly not for financial reward. If therapeutic relationships are allowed to develop, patients find that they are surrounded by compassionate persons. They are even sufficiently comforted so that they often are able to show their natural concern and compassion for each other.

The atmosphere in which rehabilitation and therapeutic work can develop with patients who are hard

to reach requires commitment, optimism or goals, and compassion. The author is forcibly reminded that these essentials in the atmosphere are none other than faith, hope, and love.

## REFERENCES


1. Appel, K. E., et al.: Complications, Sequelae, and Terminal States in Schizophrenia: A Review of the Syndrome, L. Bellak, ed., New York, Logos Press, 1958.
2. Bockoven, J. S.: Moral treatment in American psychiatry, J. Nerv. & Ment. Dis. 124:317 (Aug.) 1956.
3. Cumming, J., Director of Mental Hygiene, Mental Health Research Unit, State Office Building, Syracuse, N. Y.: Unpublished material.
4. Goffman, E.: Characteristics of Total Institutions, Symposium on Preventive and Social Psychiatry, April 15-17, 1957. Superintendent of Documents, U. S. Government Printing Office, Washington, D.C.
5. Goffman, E.: Moral career of the mental patient, Psychiatry 22:123 (May) 1959.
6. King, H. E.: Psychomotor Aspects of Mental Disease, Cambridge, Harvard University Press, 1954.
7. Ozarin, L.: Moral treatment and the mental hospital, Am. J. Psychiat. 111:372 (Nov.) 1954.
8. Rorie, J.: On the treatment of the insane sixty years ago as illustrated by the earlier records of the Dundee Royal Asylum, J. Ment. Sc. 33:1 (April) 1887.
9. Sechehaye, M.: A New Psychotherapy in Schizophrenia, New York, Grune & Stratton, 1956.
10. Sullivan, H. S.: The Interpersonal Theory of Psychiatry, New York, W. W. Norton & Company, Inc., 1953.
11. Wittkower, E. D., et al.: Object relations therapy in schizophrenic states, Second International Congress of Psychiatry, Zurich, (Sept.) 1957.



Dr. Brooks, Vermont State Hospital, Waterbury, Vt.


---

# "Rockets to Inner Space" Available Now

The Texas Medical Association, in cooperation with the Health Insurance Institute, has published a new booklet, "Rockets to Inner Space," which is being made available in quantity for use as a waiting-room publication.

A sample copy of the booklet has been sent to all members of the Texas Medical Association by Dr. A. Rex Kirkley, chairman of the association's Committee on Health Insurance. Also enclosed was an order form on which physicians may order copies in bulk. Additional booklets can be ordered free of charge from the Texas Medical Association, 1801 North Lamar Blvd., Austin.

The booklet has been written to inform both doctors and patients on subjects sometimes glossed over in the normal day-to-day relations of a patient and his doctor. It emphasizes developments in modern medical science, need for doctor-patient cooperation, and medical costs and doctors fees.

The Health Insurance Institute, which helped make the booklet available to Texas doctors, is maintained by the nation's insurance companies. It serves as the central source of information for the public on health insurance.

# *Intrathecal Use of Xylocaine*

## *--Clinical Observations--*

*Xylocaine (lidocaine hydrochloride) is not well suited for use in spinal anesthesia. Its superior diffusibility makes prediction of sensory levels of analgesia difficult.*

Gunter Corssen, M.D., and
Morris S. Miehl, M.D.

AMONG THE LOCAL anesthetic agents available for infiltration and conduction anesthesia, Xylocaine (lidocaine hydrochloride) seems one of the most promising. Its high degree of potency, comparatively low toxicity, stability in both alkaline and acid solutions and when boiled, fast onset of blocking effect, longer duration of analgesia, and pronounced penetration and diffusion power are among its desirable properties. The ability of Xylocaine to spread easily is a characteristic "most welcome to any surgeon or anesthesiologist who knows even approximately the anatomy of the nerves to be injected."[6] The unusually high penetrating capacity of Xylocaine is the predominant reason for its widespread acceptance.

Favorable reports on clinical usage of Xylocaine in local infiltration and regional anesthesia are many, but little has been written about its value for intrathecal application. Hanson and Hingson,[1] in 1950, reported 25 spinal anesthetic procedures using Xylocaine to be "entirely successful" except for blood pressure reduction in 2 patients. In 40 cases of saddle block analgesia, it was reported that when Xylocaine was administered intrathecally in doses larger than 30 mg., the sensory level obtained was too high. Southworth and Dabbs,[6] in 1953, used Xylocaine for spinal anesthesia in 19 patients. They said that the agent appears to remain localized when given intrathecally. In 1957, Moerch and others[4] analyzed in 20 patients the intrathecal concentration of lidocaine during continuous spinal anesthesia as correlated to the duration of analgesia. No complications were observed except that in 5 patients the sensory level rose to as high as T2, and in 2 patients the cervical level was reached. Since in no case was there any change in cardiovascular or pulmonary functions the authors concluded that Xylocaine was a satisfactory agent for spinal anesthesia. Phillips and coworkers[5] studied the intraspinal use of Xylocaine for vaginal delivery in 100 patients and compared the

results with those of patients who received dibucaine hydrochloride intrathecally. They stated that Xylocaine for spinal anesthesia in vaginal delivery is the agent of choice.

Although these studies reported good results, there was a lack of enthusiasm for routine use of the drug in spinal anesthesia. Since adequate analgesia appeared to be no problem, it was assumed that the tendency of intrathecally administered Xylocaine to spread rapidly through the subarachnoid space might be of disadvantage because of the inability to predict the final level of sensory analgesia and motor paralysis. The purpose of this clinical study was, therefore, to evaluate the intrathecal use of Xylocaine with special reference to its efficiency and safety in predicting the desired level of analgesia.

## Materials and Methods

A 22 gauge spinal needle with stylet was inserted into the subarachnoid space through the fourth or fifth lumbar interspace while the patient lay on the operating table in lateral position. As soon as the tip of the needle penetrated the dural sheet, the stylet was removed and a free flow of spinal fluid was established. A 5 cc. syringe containing Xylocaine-glucose solution was attached to the needle and 0.5 cc. of spinal fluid was aspirated into the syringe. The Xylocaine-glucose solution was injected at approximately 1 cc. per 3 seconds. The patient immediately was placed in supine position with the operating table kept horizontal. He was left in this position for 5 minutes. Repeated blood pressure and pulse rate determinations were taken. After the 5 minute interval, the level of analgesia was determined. Continuous recordings were made of any shifting of the level of analgesia throughout surgery. The return of sensation and motor function was recorded when the patient again could distinguish between sharp and dull stimulation and move any part of the lower extremities.

For saddle block analgesia, the patient was placed in a sitting position with the back slightly flexed. After injection of the anesthetic solution, the patient remained sitting for 5 minutes to allow fixation of the drug in the sacral region, after which the level of analgesia was determined. The patient was then placed in the position required for the surgical procedure.

Intravenous glucose, 5 per cent in water, was administered to each patient throughout surgery. Pulse rate, systolic and diastolic blood pressure, and respiratory rate were recorded at 5 minute intervals.

All spinal anesthetics of this series were administered by members of the active staff, or by the house staff, with close supervision by the former.

## Results

Of the 103 patients selected at random to whom hyperbaric Xylocaine was administered intrathecally, 87 were males and 16 were females. Their ages ranged from 16 to 89 years, with an average of 57 years.

Sensory analgesia with partial or complete motor paralysis of similar dermatomes was obtained in 102 patients. In 1 patient analgesia failed to occur, although the spinal tap procedure was performed uneventfully and the Xylocaine was injected into the subarachnoid space without difficulty.

The smallest amount of Xylocaine used was 50 mg.; the maximal dosage did not exceed 100 mg. Epinephrine 0.2 to 0.3 cc. of a 1:1000 solution was added to the hyperbaric solution in 37 per cent of the patients.

Figure 1 lists the various levels of sensory analgesia obtained.

Intrathecal injections of Xylocaine resulted in higher levels of sensory analgesia than was anticipated. An example is presented in the accompanying schematic anesthesia record. Figure 2 shows the response of a 63 year old white man to 75 mg. of Xylocaine with glucose immediately after intrathecal instillation of the drug. The sensory level obtained 1 minute after the patient was returned to the supine position was T 8. Ten minutes later, sensory analgesia was recorded at T 3, and after 25 minutes, T 2. Sensory analgesia at this level still was present at the completion of surgery, 65 minutes after the spinal anesthesia had begun.

Of the 14 patients in whom saddle analgesia was contemplated and Xylocaine was injected intrathecally with the patient in a sitting position, 5 experienced midlevel and higher spinal analgesia with sensory levels ascending up to T 4. As a rule,

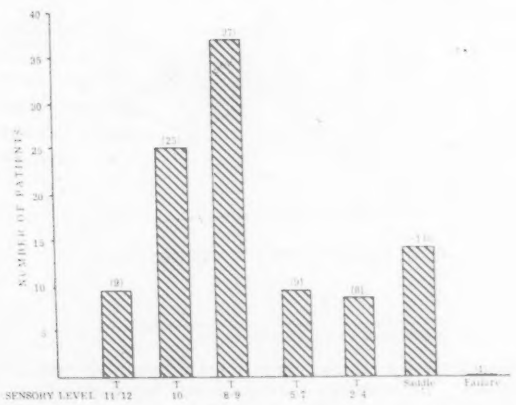



**Fig. 1.** The graph indicates the sensory level of analgesia obtained with Xylocaine in 103 patients.

blood pressure reduction occurred when the Xylocaine-glucose solution affected midthoracic or higher spinal levels. In 22 of the 103 patients, such reduction exceeded one-third of the original systolic pressure. In all instances, adequate peripheral vascular tone could be restored promptly by intravenous or intramuscular administration of vasopressor drugs such as methoxamine hydrochloride at an average dosage not exceeding 5 mg. for a single injection.

Sensory analgesia invariably was accompanied by partial or complete motor paralysis of similar dermatomes. In 29 patients with reduced respiratory activity caused by paralysis of the greater portion of the intercostal muscles, oxygen was administered by mask.

Other intraspinal and postspinal complications such as vomiting, headaches, or other neurologic disorders are not reported here because they do not pertain to this particular study.

## Discussion

Adequate analgesia occurred within 3 to 5 minutes after intrathecal injection of Xylocaine. Partial or complete motor paralysis ensued almost simultaneously. Lack of satisfactory analgesia caused delay of surgery in only 1 patient in this series. With the addition of 0.2 to 0.3 mg. of epinephrine to the Xylocaine-glucose solution, the onset of analgesia appeared to be insignificantly delayed whereas the duration of analgesic effect was slightly prolonged. This observation is in accordance with observations made by others.[4, 5]

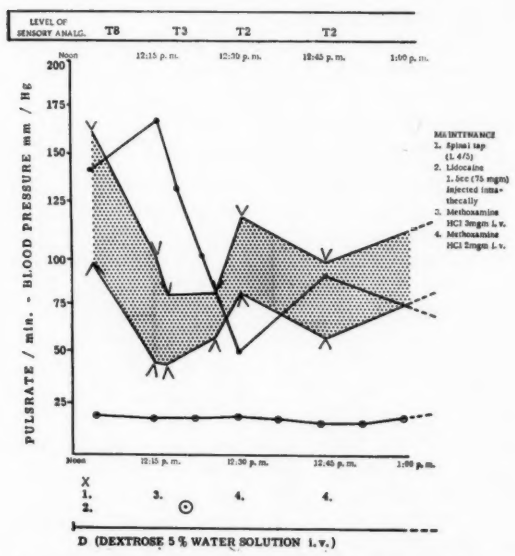



**Fig. 2.** The anesthesia record of a 63 year old man is shown. The operation performed was transurethral resection of the prostatic gland. Premedication was 50 mg. of Demerol and 0.25 mg. i.m. of Atropine at 11 a.m.

**Dr. Gunter Corssen, the senior author, formerly was assistant professor of anesthesiology at the University of Texas Medical Branch. He now is associated with the University of Michigan, Department of Anesthesiology, Ann Arbor. This paper was presented at the April, 1960, meeting of the Texas Society of Anesthesiologists in Fort Worth.**

As to the level of sensory analgesia, there was evidence that the drug behaved differently from other intrathecally administered local anesthetics. From previous experience with equipotent dosages of hyperbaric procaine and tetracaine (Pontocaine), it was found that by employing the standard technique, the sensory level of analgesia could be predicted consistently at the tenth thoracic segment. As illustrated in fig. 1, in approximately one-third of the patients a T 10 or lower sensory level of analgesia was produced, whereas the remainder of the patients experienced analgesia at a higher sensory level than was anticipated. In 17 patients the analgesic level rose higher than T 8; in 8 patients, sensory and motor paralysis involved the fourth, third, and second thoracic segments. The gradual ascension of the sensory level of 2 or more thoracic segments was observed as late as 60 minutes following the intrathecal use of Xylocaine. In 5 of 14 patients in whom analgesia of the saddle region was contemplated, not only the saddle area but the entire lumbar region and the lower and middle thoracic region was affected.

Pronounced reduction of the systolic blood pressure occurred in 22 of the 103 patients; it usually was observed in conjunction with the unexpected rise of the level of sensory analgesia, and undoubtedly was the result of reduced sympathetic tone. Small amounts of methoxamine hydrochloride (Vasoxyl) promptly restored the blood pressure to normal levels in these patients.

These observations suggest that Xylocaine, intrathecally administered, frequently failed to become fixed at a sensory level which can be established under identical conditions using hyperbaric procaine or Pontocaine solutions. In all probability, the superior diffusibility of Xylocaine is a disadvantage in spinal anesthesia because of the tendency of the agent to spread beyond the desired limits. Since the lack of early fixation seems to be a predominant feature

of the drug when it is used intrathecally, and frequently causes profound blood pressure reduction, its use for spinal anesthesia should be discouraged. Safer and equally potent drugs are available.

## Summary

A clinical evaluation of the safety of Xylocaine for intrathecal administration has been conducted in 103 patients who had various surgical procedures involving the pelvis, perineum, and lower extremities.

From previous experience with equipotent dosages of hyperbaric procaine and tetracaine, it was established that with a standard technique, the sensory level of analgesia consistently could be predicted within 1 or 2 segments.

In more than 50 per cent of the spinal anesthetics administered in this series with hyperbaric Xylocaine, the sensory level obtained was higher than anticipated. In approximately one-third of the patients, the drug failed to become fixed at the level established 5 minutes after intrathecal injection. In these instances, a gradual ascension of the sensory level of 2 or more thoracic segments could be observed as late as 60 minutes after intrathecal use of the drug.

The superior diffusibility of Xylocaine, one of its valuable properties for facilitation of conduction analgesia, appears to be disadvantageous in spinal anesthesia because of the tendency of the agent to spread beyond the desired limits.

## REFERENCES

1. Hanson, I. R., and Hingson, R. A.: Use of Xylocaine, New Local Anesthetic, in Surgery, Obstetrics, and Therapeutics; Preliminary Report, Anesth. & Analg. 29:136 (May-June) 1950.
2. Loefgren, N.: Studien ueber Lokalanaesthetika, Arkiv Kemi, Mineral. Geol. 22A:18 1946.
3. Loefgren, N., and Lundquist, B.: Studies on Local Anesthetics II., Svensk Kem. Tidskr. 58:206 1946.
4. Moerch, E. T.; Rosenberg, M. K.; and Truant, A. T.: Lidocaine for Spinal Anesthesia, Acta Anaesth. Scandinav. 1:105 1957.
5. Phillips, O. C.; Nelson, A. T.; Lyons, W. B.; Graff, T. D.; Seebert, C. T.; and Frazier, T. M.: Spinal Anesthetic Agents for Vaginal Delivery; Comparison of Xylocaine and Nupercaine, Obst. & Gyn. 11:680 (June) 1958.
6. Southworth, J. L., and Dabbs, C. H.: Xylocaine: Superior Agent for Conduction Anesthesia, Anesth. & Analg. 32:159 (May-June) 1953.

*Two cc. ampules of lidocaine (Xylocaine) (containing 100 mg. of lidocaine and 150 mg. of glucose) were supplied by Astra Pharmaceutical Products, Inc.*

♦ Dr. Corssen, University Hospital, Ann Arbor, Mich.
Dr. Miehl, John Sealy Hospital, Galveston.

---

## Do you "Know" These Physician-Writers?

| | |
|---|---|
| Hippocrates | St. Luke |
| John Keats | Chekhov |
| Sir William Osler | Oliver Wendell Holmes |
| A. J. Cronin | Albert Schweitzer |
| Frank Slaughter | Somerset Maugham |

William Carlos Williams

# Post-traumatic Infraorbital NEURALGIA

*Months after a fracture of the maxillary zygomatic complex, infraorbital neuralgia occasionally appears. Prolonged investigation for neuralgia may be avoided if a history and clear roentgenograms are obtained. Two treatment methods may be followed: neurolysis by injection or actual decompression.*

**BROMLEY S. FREEMAN, M.D.**

THE RISING INCIDENCE of fractures of the maxillary zygomatic complex is proportional to the increase in automobile accidents. Damage often is confined to the fragile supports of the zygoma, especially to the infraorbital rim in the region of the infraorbital foramen, and to "blow-outs" of the infraorbital floor with direct injury of the infraorbital canal. Evidence of injury to the infraorbital nerve is frequent, immediate, and classical. An infrequent complication, not always recognized, is ingravescent infraorbital neuralgia months after the injury or reduction of the fracture.

The intramaxillary portion of the infraorbital nerve and artery runs in a channel of paper thin bone (Fig. 1). Fragmentation of this canal, or of the adjacent antral walls, results in razor-sharp bone fragments which can lacerate a long, thick nerve against the dense infraorbital ridge. Collapse of the infraorbital rim, with compression of the nerve in the foramen, or between fractures, results in the nerve being caught in the callus or scar. Symptoms

**Fig. 1.** Sharp fragments of fractured infraorbital canal.

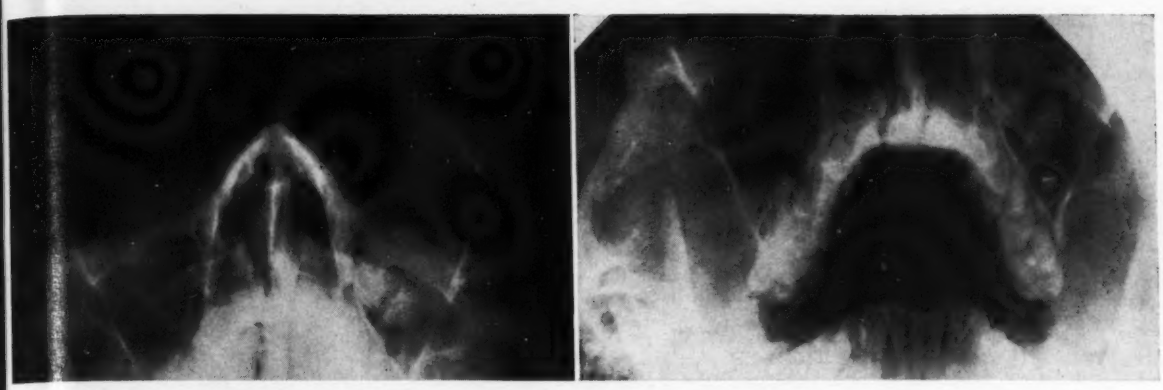


Fig. 2. Roentgenograms of J. A. in Waters and modified Waters position, showing maxillary fracture with left infraorbital canal abnormality.

become apparent as the scar contrasts. Several patients with midfacial fractures impacted in grossly adequate positions had no operative intervention. Signs of ingravescent second division neuralgia, several months later, led to roentgen-ray study. Operative diagnosis was infraorbital foramen crush, with resultant traumatic neuritis of the infraorbital nerve.

Clinically, the cases reviewed fell into four groups. The first group contained patients with zygomatic or orbital floor fracture, with usual post-traumatic numbness, followed months later by a temporary acute hyperesthesia, which subsided after symptomatic treatment with analgesics and reassurance.

The second group of patients had more persistent postreduction neuralgic pain, with normal appearing infraorbital foramina by roentgen ray. Pain was relieved by mechanical or chemical neurolysis. Injections of a combination of Xylocaine and hyaluronidase of various amounts into a scar "neuroma" at the orifice of the foramen or into the foramen relieved most patients after two injections. One patient was not helped after four injections. In this case, exploratory operation permitted the removal of a stainless steel interosseous wire suture. The cut ends had pressed directly on the nerve sheath.

The third group included patients with an unreduced step fracture of the infraorbital rim and/or of the anterior wall of the maxilla with fibrous union, or an unstabilized fracture fragment.

Despite the ordinarily too rapid fixation of zygomatic fractures in malposition, occlusal pressure on the teeth transmitted movement to a loose sharp fragment adjacent to a vulnerable nerve in 2 patients.

The fourth group included patients with adequately reduced fractures, but with late onset of persistent tingling in the nerve area. These cases developed ingravescently from hypersensitivity to "spontaneous" pain with atypical radiation. This group represented "interesting problems," and some patients were seen by the neurosurgeons or neurologists for the possibility of *tic douloureux*.

The first two groups mentioned contained common minor complications of midfacial fractures. The third group was easily diagnosed by roentgen ray. The fourth required a moderate index of suspicion.

**Dr. Bromley S. Freeman is Clinical Associate Professor of Surgery (Plastic) with the Department of Surgery, Division of Plastic Surgery, Baylor University College of Medicine, Houston.**

## Case Reports

CASE 1.—An example of the third group was J.A., who was seen in consultation during hospitalization in 1956 for "intractable pain over the left maxillary region, ascending to the left temporal region and to the globe." He had a typical "trigger-zone" in the left temporal region. Clipping the hair or shaving over this area, touching the left nasal fold, or grinding dental pressure when he was chewing set off paroxysms of pain. Eighteen months previously he had broken a cheek bone, but reduction was thought to be unnecessary by the emergency room physician.

Examination showed a typical depressed fracture of the left lateral aspect of the orbital floor, tenderness over the entire maxillary sinus, and a hard nodule over the buccal mucosa of the canine cul-de-sac. There were two extremely sensitive trigger-zones—the left alae nasi and a subcutaneous 4 mm. scar in the upper left temporal fossa. There was no evidence of infraorbital anesthesia, diplopia, or trismus. Roentgen rays confirmed the clinical impression of maxillary fracture, with an infraorbital canal change on

the left. The illustrations showed the roentgenograms in the patient in Waters and modified Waters position (Fig. 2).

Through a buccal incision, the infraorbital vessels and nerves were exposed, traced, and found to be caught in a fibrous scar "callus." Pressure on the maxillary cuspids pressed a spear-shaped sharp fragment directly against the nerve. The infraorbital nerve was freed and isolated, the fragment replaced, and the floor of the bony canal removed with a chisel, leaving the inferior aspect of the nerve free. A small piece of polyethylene film was slipped around the nerve to lessen later perineural adhesions. Since 1956 the patient has had no return of symptoms.

CASE 2.—Typical of the fourth group was T.W., an 18 year old white man with multiple facial fractures. He initially was treated by an otolaryngologist; later a plastic surgeon openly reduced the left zygomatic fracture and packed the left maxillary antrum for fixation.

Three months after the operation the patient complained of severe pain at the slightest touch on the left side of the face, and intolerable "boring pressure" between his eyes and nose when he chewed. These symptoms were progressive, persistent, and emotionally disturbing. The essential points of physical examination were an exquisitely sensitive, left anterior antral wall, buccal sulcus, and root of the maxillary spine. There were hyperesthesia of the infraorbital area, slight notching of the left infraorbital rim, and a trigger-zone of acutely severe pain experienced when the site of the infraorbital canal was tapped. With the maxillary nerve blocked by local anesthesia, a firm scar could be palpated at the infraorbital foramen. Roentgenograms showed displacement of the left infraorbital rim with an exaggerated fracture of the left zygomatic arch, although externally the structure appeared normal (Fig. 3).

**Fig. 3.** Roentgenogram of T.W., showing old fracture of the left zygomatic arch and displacement of infraorbital rim.

It was the author's impression that the patient had left infraorbital neuritis, with the fractured bone pressing on a segment of the nerve.

Exploratory operation through an external incision showed the infraorbital nerve firmly bound in callus (Fig. 4). Dissecting the nerve and chiseling a wider "infraorbital foramen" permitted a small segment of polyethylene tubing to be slipped over the nerve to prevent further adhesions. This procedure has relieved the patient completely for the past 2 years.

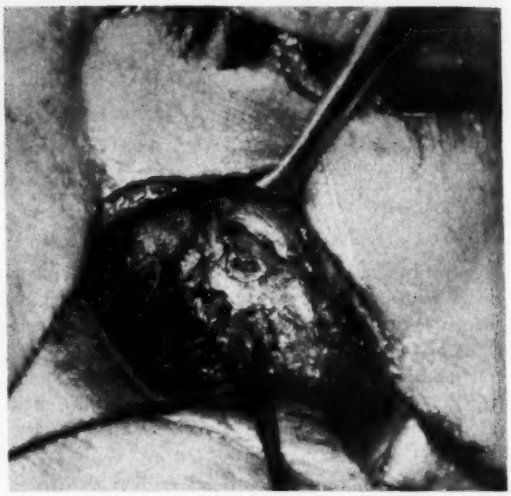


**Fig. 4.** Photograph showing infraorbital nerve firmly bound in callus.

## Summary

Before a patient undergoes prolonged investigation for an esoteric atypical neuralgia, such as one secondary to "vascular pain," ganglionitis sympatheticalgia, or facial psychalgia, the possibility of post-traumatic infraorbital neuritis should be considered and empiric treatment assayed. With a history and clear roentgenograms, diagnosis rarely can be missed. If neurolysis by injection does not aid, actual decompression is simple. It can be done through the buccal route and may prevent a prolonged, delayed, and agonizing work-up for pain of "obscure origin."

Dr. Freeman, 1810 Medical Towers, Houston 25.

# Pediatric Infections

## *Use of Broad Spectrum Antibiotics*

*The author believes that it is nearly always desirable to begin effective therapy before bacterial susceptibility is determined in infants and children with infections. The antibiotic chosen should cover most of the possibilities; tetracycline and oxytetracycline are highly effective in such cases. Results in 143 miscellaneous infections in pediatric patients are reported.*

**FREDERICK W. GROVER, M.D.**

*Hardly any physician will deny the desirability of utilizing, whenever possible, the most precise techniques available for the diagnosis and treatment of disease. Nevertheless, the cause of truth is ill served if medical practitioners pretend that this goal is always attainable, even by those physicians most devoted to the practice of scientific medicine. It appears almost certain, for example, that the majority of common infections are treated without benefit of bacteriologic study, not because of the ignorance or negligence of physicians, but as a result of the sheer magnitude of the problem and the cumbersome and time-consuming nature (not to mention the frequently equivocal results) of the laboratory techniques in question. The practicing physician knows very well that it is neither possible to examine all such patients nor always to be certain, even in those examined, whether a bacterial or viral agent is involved. Under these circumstances it is inevitable, though perhaps not necessarily desirable, that many short courses of broad spectrum antibiotics will be prescribed on the basis of clinical impression alone. It is therefore justifiable that some information on the results of such a practice be made available. In this spirit the* TEXAS STATE JOURNAL OF MEDICINE *presents Dr. Grover's account of his experiences in the management of pediatric infections.*

IT HAS BECOME standard practice to treat pediatric patients who have infections with the tetracyclines because the drugs are both effective and well tolerated. Young patients, like the old and the debilitated, may suffer from two or three infections simultaneously, and more than one pathogen is likely to be involved. It is nearly always desirable to begin effective therapy before bacterial susceptibility can be determined, and the antibiotic chosen would accordingly be one that can be expected to cover most of the possibilities. Nathan[5] reported that there was no reliable correlation between sensitivity testing and clinical results. Two of his patients responded well to tetracycline despite in vitro evidence of bacterial

TABLE 1.—*Diagnoses in 143 Cases of Infections in Infants and Children.*

| | Single infection | In conjunction with a second infection | In conjunction with 2 other infections | Total |
|---|---|---|---|---|
| Upper respiratory tract infection | 7 | 64 | 16 | 87 |
| Otitis media | 12 | 20 | 5 | 37 |
| Bronchitis with or without asthma | 1 | 32 | 9 | 42 |
| Pneumonia, pneumonitis | 25 | 27 | 5 | 57 |
| Pertussis | | 4 | 2 | 6 |
| Measles | 1 | 1 | | 2 |
| Gastrointestinal infection | 3 | 4 | 3 | 10 |
| Genitourinary infection | | 1 | | 1 |
| Infection of skin and soft tissue | 1 | 5 | 2 | 8 |
| Total | 50 (50 pts.) | 158 (79 pts.) | 42 (14 pts.) | 250 (143 pts.) |

resistance. There were 9 failures among his 50 cases of upper respiratory tract infection, however, because of his rigid criterion of classifying as successful only those in which improvement occurred within 4 days. Other authors[1-4, 6, 7] have had almost no failures with the broad spectrum antibiotics. Mathieu,[3] for example, reported complete success in treating miscellaneous pediatric infections with tetracycline, and suggested that the absence of undesirable side effects might be attributed in part to the fact that the preparations used contained glucosamine.

## Materials and Methods

The present study is concerned with the treatment of 143 infants and children, 73 of them male and 70 female. Ages ranged from 4 weeks to 13 years, with an average of 13 months and a median of 25 months. Fifty of the patients had one infection only; 79 suffered from two infections simultaneously, and 14 from three. The diagnoses are shown in Table 1.

Many of the patients in the present series were severely ill, frequently with fever of 103 to 104 F., and in some cases as high as 106 F. Seven patients had failed to respond to penicillin or another antibiotic. Bacterial studies were not done in most cases, partly because it was desirable to spare expense to the patients, partly because it was anticipated that most pathogens would be susceptible to the broad spectrum antibiotics whether or not testing was done, and partly because it was expedient to begin therapy without delay, especially in the more serious cases. Progress of chest infections was followed by roentgenographic examination.

The antibiotics used were tetracycline and oxytetracycline.* Dosage varied according to the severity of the infection, but was usually 35 to 40 mg. every 6 hours in infants younger than 2 months, 50 to 60 mg. in those up to 1 year old, and 60 to 125 mg. in those between the ages of 12 and 24 months. The most frequent dosage for older children was 125 mg. every 6 hours, but a few were given less and many were given more. The highest dose was 250 mg. every 6 hours, reserved for serious infections in older children. Dosage was usually continued for 2 days after fever and other signs of infection had subsided. Penicillin was administered in conjunction with the tetracyclines in 18 cases, usually for not more than 2 to 4 days. An antipyretic was prescribed in 2 cases, a cough mixture in 4, and hydroxyzine with prednisolone in 2 cases of asthma. Adjunctive treatment for asthma included use of a bronchodilator, hyposensitization procedures, and steam treatment in 1 case each. Surgery was performed in only 3 cases, and consisted of incision of an abscess and myringotomy in 2 cases of otitis media.

Treatment was domiciliary in nearly all cases. Most of the children were seen initially as outpatients at the Freeman Memorial Clinic and home treatment was supervised by house telephone calls and clinic visits as frequently as was deemed necessary. All patients received from 2 to 6 follow-up examinations in the clinic according to the severity of their condition. Only 5 of the children were hospitalized, either because of the seriousness of their condition or because they failed to receive proper treatment at home.

## Results

There were no therapy failures. Fever was controlled rapidly and recurred in only 3 cases. In 2 of these medication had been discontinued prematurely; the third patient had pneumonia which was responding satisfactorily, but his temperature rose again when he drank turpentine. Fever subsided promptly

*Tetracycline was given in the form of Cosa-Tetrabon Oral Suspension (64 cases) or Pediatric Drops (23 cases) and Cosa-Terrabon Oral Suspension (48 cases) or Pediatric Drops (8 cases). These preparations were supplied by Pfizer Laboratories.

in these cases when tetracycline dosage was begun again, in conjunction with penicillin. In none of the 18 cases in which penicillin was used was there any indication that response was more rapid than the response to the tetracyclines without penicillin, nor was there any detectable difference in the response to tetracycline and oxytetracycline.

Beta hemolytic streptococci were identified in 4 cases of respiratory infection and in 1 case of gastroenteritis; staphylococci in 1 case each of respiratory infection, otitis media, and gastroenteritis; and diplococci in some of the cases of pneumonia. No pathogen could be recovered in a case of pneumonia and one of enteritis, from which it was concluded that these were viral infections. The type of organism identified did not appear to have any bearing on the response to treatment.

Upper respiratory infection usually abated within 48 hours of the initiation of therapy and always in less than a week, although rhinorrhea sometimes persisted a little longer. Fever in otitis media was nearly always controlled within 2 days, and the ears were apparently normal in 4 to 7 days. One of the patients with upper respiratory tract infection and otitis media also had a gluteal abscess. He was treated with penicillin as well as with the usual dosage of tetracycline, and the abscess was incised.

**Dr. Frederick W. Grover of Dallas is a specialist in allergic diseases. He formerly was a fellow in allergy at the Children's Medical Center, and was associated with the Department of Pediatrics of the University of Texas Southwestern Medical School.**

All signs of infection disappeared within 4 days, although a slight cough continued for 8 days. Response in pneumonia was uniformly gratifying. Temperature returned to normal in 2 to 3 days as a rule. The lesions resolved within a week in nearly all cases, although in a few cases rhonchi or rhinorrhea persisted a little longer. Results in bronchitis were similar. Fourteen of these patients were asthmatic. The asthma was precipitated or aggravated by upper respiratory infection, and subsided when the infection was controlled in all but 1 case. One patient admitted with status asthmaticus had no therapeutic response to epinephrine, but as the infection resolved promptly, respiration became normal. Response to treatment was equally good in the 6 cases complicated by pertussis. In the 10 cases of gastroenteritis, diarrhea, abdominal pain, and vomiting ceased in 2 to 3 days and stools became entirely normal in 4 to 5 days. Complicating infections were controlled in all cases.

Many of the infections had occurred as sequelae to measles, and one child had measles in conjunction with otitis media. No further complications developed in this case. For this reason antibiotic treatment was given for a week in a case of uncomplicated measles, and sequelae were prevented.

There were no undesirable reactions to the antibiotics used. Not only were all preparations well tolerated, but even the most difficult and uncooperative patients accepted the medication willingly.

## Summary

Tetracycline and oxytetracycline were used in 143 miscellaneous infections in pediatric practice. Most of the patients had more than one infection simultaneously, and many of them were seriously ill. Fever and other signs of infection were controlled in all cases, and there were no undesirable side effects. The author concluded that tetracycline and oxytetracycline are highly effective in the treatment of infants and children with infections.

## REFERENCES

1. Berry, D. G.; Fry, J.; Hindley, C. P.; Hodson, J. M.; Horder, E. J.; Horder, J. P.; Marien, E. A. W.; Rea, J. N.; Ryle, A.; Curwen, M. P.; and Tomlinson, A. J. H.: Exacerbations of Chronic Bronchitis; Treatment with Oxytetracycline, Lancet 1:137 (Jan. 16) 1960.

2. Gould, J. C., and Murdoch, J. M.: Long-term Management of Chronic Bronchitis with Antibiotics, in Antibiotics Annual 1959-1960, New York, Antibiotica, Inc., 1960.

3. Mathieu, P. L., Jr.; Wang, S. Y.; Toselli, A.; and Mathieu, B. B.: Glucosamine-potentiated Tetracycline in Pediatrics, Rhode Island M. J. 42:172 (March) 1959.

4. Murdoch, J. M.; Leckie, W. J. H.; Downie, J.; Swain, R. H. A.; and Gould, J. C.: An Evaluation of Continuous Antibiotic Therapy in Chronic Bronchitis, Brit. M. J. 2:1277 (Dec. 12) 1959.

5. Nathan, L. A.: Use of Glucosamine-potentiated Tetracycline in Treatment of Upper Respiratory Infections in Children, Arch. Pediat. 75:251 (June) 1958.

6. Pagola, J. G.; Heredia, A.; and Carrillo, J.: Two Hundred Cases of Bronchopneumonia Treated with Combination of Oxytetracycline-oleandomycin, in Antibiotics Annual 1959-1960, New York, Antibiotica, Inc., 1960.

7. Ritchie, J. M.: Control of the Common Cold by Autogenous Vaccine or by Antibiotics, in Welch, H., and Marti-Ibañez, F., eds.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 174.

Dr. Grover, 310 Medical Tower, 712 N. Washington, Dallas 10.

---

## Sucker, Anyone?

A nice man called up the Children's Medical Center in Boston. He'd been thinking about making a contribution to the hospital, he said, and would like to furnish the lollipops handed out to patients. Could someone tell him about how many lollipops the hospital used in a year? Someone could: 93,000.

—From *The Modern Hospital.*

# Prostheses

# In Otosclerosis Surgery

*When total stapedectomy is necessary, tantalum and alloy steel prostheses have given more satisfactory results than polyethylene ones. Anti-inflammatory agents offer partial protection from labyrinthine reactions.*

W. P. Anthony, M.D.

OTOSCLEROSIS is a common cause of progressive loss of hearing in early or middle adult life. An osteodystrophy of the labyrinthine capsule (fig. 1), it results in ankylosis of the stapes, or stirrup, the last of the chain of three bones that carries sound from the ear drum to the cochlea and auditory nerve (fig. 2). The stapes becomes fixed and unable to vibrate, and sound no longer reaches the sound perception mechanism of the inner ear.

The cause of otosclerosis is not known. There is a tendency for it to run in families, and about half the patients have a relative with the same condition. The loss of hearing in otosclerosis occurs gradually and progresses slowly and irregularly. In some cases, the level of hearing remains stationary for many years; in other cases, the hearing becomes progressively worse. Pregnancy tends to cause an increase in the deafness.

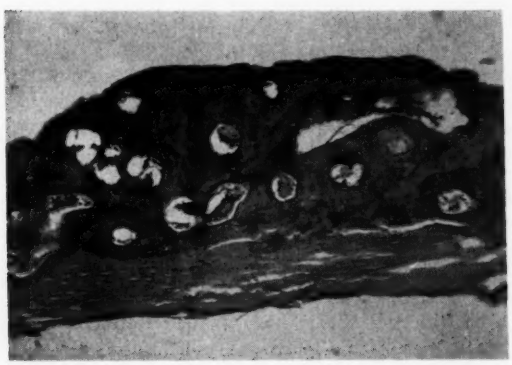


**Fig. 1.** The otosclerotic bone (top) is more spongy in appearance than is the normal bone of the labyrinthine capsule.

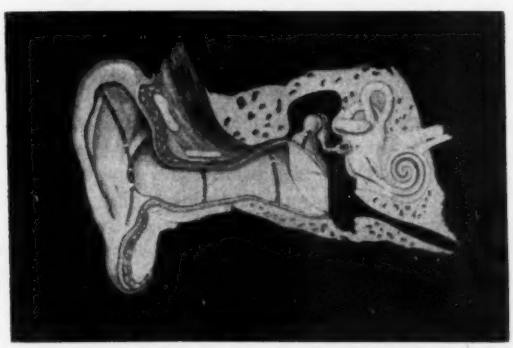


**Fig. 2.** This drawing shows normal hearing mechanism. Curved lines represent the pathway of sound to cochlea.

Stapes mobilization and partial or total stapedectomy with replacement by a prosthesis, like the old fenestration operation, are used in the surgical treatment of patients with otosclerosis.

In mobilization surgery, a gentle attempt is made to free the stapes from its otosclerotic fixation so that sound vibrations again can pass from the ear to the hearing nerve. After Rosen[9] introduced this operation, the old laborious Lempert fenestration, with its tedious after-care, was abandoned. When more than the expected numbers of refixations of the stapes occurred, the idea of returning to the classical fenestration was poorly accepted by otologist and patient alike. I reported a method[1] of tympanotomy and inspection of the oval window area which could be followed either by stapes mobilization in favorable cases, or classical fenestration in unfavorable cases. However, the concept that the future of all otosclerosis surgery lies at the oval window, supported by the ingenious techniques of stapes substitution proposed by Shea,[11] Schuknecht,[10] and Portmann[8] has by this time become the generally accepted modus operandi (figs. 3 and 4).

What is the status of this surgery today? Improvement in hearing is obtained in nine of ten operations, but there are two important unsolved problems. What is the ideal material for use as a prosthesis in the middle ear? The second and even greater problem is what can be done to avoid the serious labyrinthine reactions that occasionally occur as a result of stapedectomy and replacement by a prosthesis.

This paper shows ways to cope with these two problems. The use of metal prostheses is supported, as opposed to the use of the plastic polyethylene.

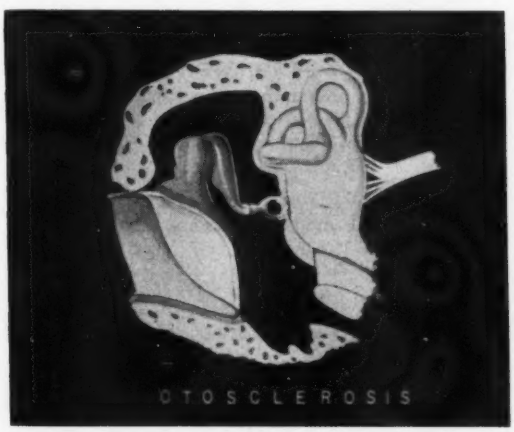



**Fig. 3.** An otosclerotic process has invaded the stapes and resulted in ankylosis. The sound conducting mechanism has been interrupted.

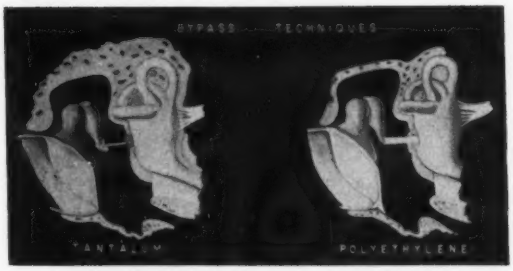



**Fig. 4.** The ankylosed stapes is removed and replaced by (left) a subcutaneous tissue graft to seal the oval window and a tantalum or alloy steel prosthesis (left). A vein graft and polyethylene prosthesis are used in the illustration on the right.

Observations in five reoperations on ears into which polyethylene had been placed are reported. The use of anti-inflammatory agents postoperatively to minimize labyrinthine reaction is mentioned, and a preliminary report of 100 cases in which metal prostheses and grafts were used after stapedectomy, according to the method of Schuknecht, is presented.

The steel or tantalum technique was adopted for the following reasons:

1. Malleability of metal facilitates placing the graft directly in the window without saucerizing, which is traumatic and time consuming. One surgeon has noted a 4 mm. growth of bone over the oval window area at reoperation in a case in which a moderate amount of drilling had been necessary.

2. Stainless steel and tantalum suture material seem to have been tolerated for years in the human body.

3. Obtaining the graft from the lobe of the ear is more convenient than having to prepare a distant site for obtaining vein graft.

4. A metal prosthesis can be more securely fixed in position. One end encircles the incus, and the other is tied into the graft which is fitted snugly into the oval window. In contrast, a polyethylene tube must be wedged medially between an unfixed graft, and its only support laterally is the spring of the ossicular chain.

5. After operation, massive otosclerotic growths or fibrous reactions may crowd and immobilize something as bulky as a polyethylene tube, but these are less likely to immobilize a fine shaft of 5-0 wire.

6. The popularly used polyethylene is *known* to produce tumors resembling fibrosarcoma in 10 to 12 per cent of rodents in which it has been implanted.[2, 6] Thus far, no such occurrence has been reported in man, but it might be in the next five to fifty years.

7. The chemical composition of polyethylene is not constant. The complicated macromolecular structure varies from batch to batch as it is produced, and each batch must be assayed in animal testing for

Dr. W. P. Anthony, Fort Worth otolaryngologist, presented this paper at the annual meeting of the Texas Otolaryngological Association in Ft. Worth April 11, 1960.

tissue foreign body reactions. Samples of each batch are implanted in the back muscles of rabbits for two weeks, then mounted and checked microscopically for such reactions.[7] Foreign body reactions locally within a day or so are not considered important. A batch is rejected only if *two or more specimens* produce a reaction which is present at the end of two weeks. Therefore, in using "animal tested" polyethylene, the surgeon is reasonably safe from overt foreign body reactions, but the results of implanting this material in the human middle ear for 50 years are not known.

8. Surgical examination of five middle ears in which polyethylene had been present for from 109 to 354 days revealed inflammatory reactions in the middle ear mucosa in contact with polyethylene in the only three cases from which specimens were obtained. Four of the five polyethylene struts were out of position, and resulted in discontinuity of the sound conducting mechanism. In one case a labyrinthine fistula had developed.

## Case Reports

CASE 1.—The tube was lying out of position as though it had just been dropped into the cavity. It had been in the tympanum 109 days. There was no evidence of inflammatory reaction at 16 power magnification. The tube was not covered by membrane. No tissue was recovered for pathologic study. The previously fragmented footplate had completely healed and was solid.

CASE 2.—The prosthesis had been present for 207 days. It had been placed on a shattered footplate, and had remained in good position. A labyrinthine fistula had resulted, and was complicated by serous otitis media. The middle ear membranes were subacutely inflamed, and almost completely covered the tube. Perilymph pulsated from the medial contact of the tube with the oval window area. The tube was removed and saved. The pathology report read, "Small benign segments of fibrous tissue showing severe chronic inflammation. No anaplastic changes demonstrated."

CASE 3.—The polyethylene prosthesis had been in place 255 days. It was out of position laterally. Medially, it rested on the footplate area and was about one-half covered by membrane. Fairly heavy scars were present beneath it with some increased vascularity in the area. The tube was filled with amber colored liquid, with what appeared to be a whitish precipitate at its dependent end. The tube and its contents were lost before a smear or culture could be made. However, the membrane in the area was removed for pathologic study. The pathology report read, "Small benign segment of fibrous tissue showing mild chronic inflammation and calcification."

CASE 4.—The prosthesis had been in the tympanum for 132 days. It was out of position at its union with the incus. There was no evidence of inflammation at 16 power magnification. The tube was completely covered by membrane which was connected with the footplate membrane medially and the incus membrane laterally. The sheath of tissue covering the tube was recovered for pathologic study. The pathology report read, "Segment of mucosa showing mild chronic inflammation and fibrosis."

CASE 5.—The polyethylene had been in the tympanum for 354 days. The tube's lateral end had separated from the incus, and moved posteriorly where it was unattached. Three-fourths of the tube was covered by mucous membrane, which did not appear inflamed. At the time of surgery, the tube had been placed on a large, free center fragment of footplate with no graft of any kind. When removed, the edge of the medial end rested on thin blue membrane which was freely moveable. Heavy thick scar tissue rose about 1 mm. around this blue area, and seemed to have tightened around the medial end of the tube. Pressure on the membrane produced a round window reflex. The footplate fragment upon which it had rested seemed to have been absorbed.

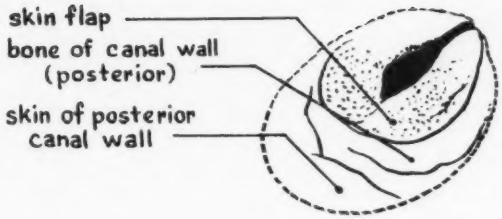
More than 100 operations have been performed in which stapedectomy was followed by replacement with subcutaneous tissue graft and metal prostheses. One hundred patients had been followed for three months postoperatively at the time of this report. Results have been uniformly good. The air-bone gap was closed 75 per cent or more in 80 per cent of cases.

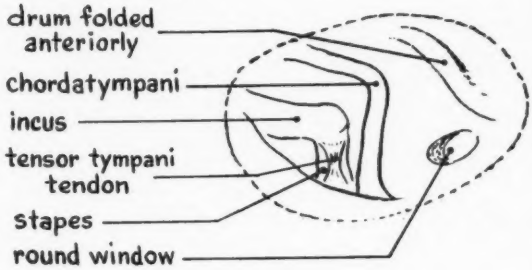
Almost invariably the gain in hearing evident in the three month audiogram was greater than at three weeks. There were no regressions at three months. No patient's hearing was made worse by this operation and no catastrophic cochlear degenerations were encountered; however, in one case, a cochlear loss of greater than 20 decibels was encountered, neutralizing closure of the air-bone gap.

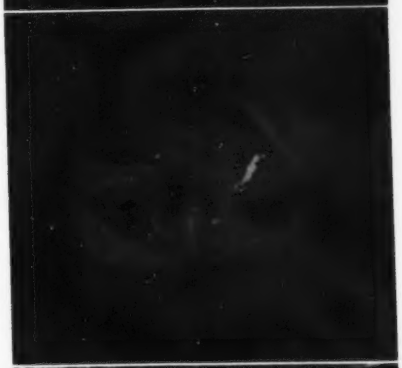
There was, almost uniformly, a moderate to severe dip in the audiogram at the 4,000 and 8,000 frequencies postoperatively. This often extended to the left, causing a five to twenty decibel dip at a frequency of 2,000 at three weeks. This dip tended to level out at three months, but sometimes did not do so completely.

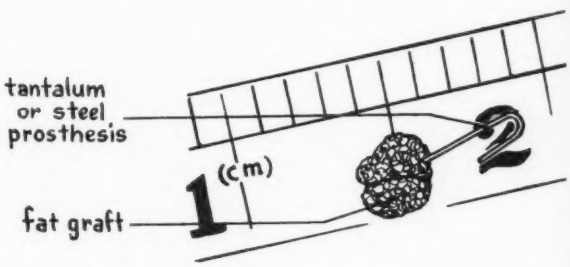
## Trypsin and Streptokinase

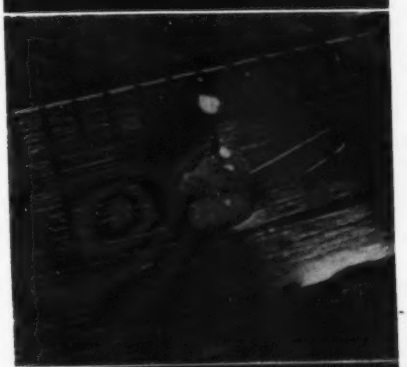
That stapedectomy is traumatic to the labyrinth is unquestionable. Singleton and Schuknecht[12] have shown that all penetrating lesions of the footplate or inward subluxation of the stapes consistently result in injury to the saccule, to Reissner's membrane, and

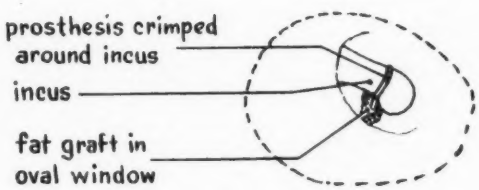

skin flap
bone of canal wall (posterior)
skin of posterior canal wall

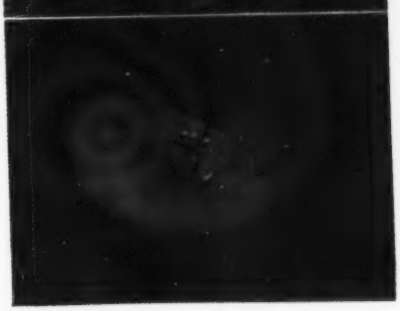

drum folded anteriorly
chordatympani
incus
tensor tympani tendon
stapes
round window




tantalum or steel prosthesis
1 (cm)
2
fat graft




prosthesis crimped around incus
incus
fat graft in oval window



the organ of Corti in the upper basal turn. The number of reported cases is mounting. For that reason, inflammation suppressing drugs such as trypsin or streptokinase are used routinely following such operations, and following any trauma to the footplate in ordinary stapes surgery.

Trypsin is able to activate the intrinsic plasma fibrinolytic system, and is useful as an anti-inflammatory agent in a wide variety of disorders that produce acute inflammation.[5]

Streptokinase and streptodornase (Varidase) act to trigger the natural specific proteolytic system of the body.

Martin[4] believes that in the initial inflammatory reaction, the pore size of the protein mesh in the capillary cells and tissues is modified to permit passage into the tissue spaces of small molecular units and macromolecules. Fibrinogen passing through the protein network is converted into a labile form of fibrin, thus blocking and trapping intercellular fluid. Biological continuity is eliminated, isolating the lesion.

Varidase or trypsin,[3] then, tends to retard the normal destructive inflammation pattern. The chain reaction of (1) capillary congestion and dilatation with increased permeability, (2) disposition of macromolecular protein in tissues causing edema, (3) swollen capillaries, thrombus formation, hypoxia, and protein wall formation around the traumatized area is suppressed, allowing the traumatized area to survive serious damage that might destroy function of a delicate sensory organ such as the cochlea.

By careful technique and the use of inflammation suppressing drugs, it is possible to minimize postoperative nausea and vertigo and to minimize reactions that otherwise might produce gross damage to the labyrinth.

## Summary and Conclusions

Polyethylene is challenged as the material of choice for middle ear prostheses in surgical treatment of patients with otosclerosis in which total stapedectomy is necessary.

A series of cases in which tantalum and alloy steel were used as prostheses in the middle ear is presented. Results were encouraging.

The use of anti-inflammatory agents after trauma to the footplate or stapedectomy is proposed as a possible way to prevent serious labyrinthine reactions with loss of cochlear function.

## REFERENCES

1. Anthony, W. P.: Practicability of immediate fenestration after stapes mobilization failure, Laryngoscope 68:1950 (Nov.) 1958.
2. Bering, E. A., Jr., et al.: The production of tumors in rats by the implantation of pure polyethylene, Cancer Research 15:300 (June) 1955.
3. Davidson, E.; Prigot, A.; and Maynard, A.: Buccal varidase as an adjunct in the therapy of inflammatory lesions, hematoma and traumatic edema: a preliminary report, Harlem Hospital Bulletin 11 (June) 1958.
4. Martin, G. J.: Trypsin, pharmacology of drug, Exper. Med. & Surg. 13:156 1955.
5. Moser, K. M.: Intramuscular injection of trypsin: its value as a thrombolytic and anti-inflammatory agent, N.E.J. Med. 256:258 (Feb.) 1957.
6. Oppenheimer, B. S.; Oppenheimer, E. T.; and Stout, A. P.: Sarcomas induced in rodents by imbedding various plastic films, Proc. Soc. Exper. Biol. and Med. 79:366 (March) 1952.
7. Palmer, D. H.: Personal communication to the author.
8. Portmann, G.; Portmann, M.; and Claverie, G.: La chirurgie de la surdite, ed. 2, Librairie Arnette, 1960.
9. Rosen, S.: Mobilization of the stapes to restore hearing in otosclerosis, New York J. Med. 53:2650 (Nov. 15) 1953.
10. Schuknecht, H. F.: Personal communication and American Academy of Ophthalmology and Otolaryngology course, 1959.
11. Shea, J. J., Jr.: Fenestration of the oval window, Ann. Otol. Rhin. & Laryng. 67:932 (Dec.) 1958.
12. Singleton, G. T., and Schuknecht, H. F.: Experimental fractures of the stapes in cats, Ann. Otol., Rhin. & Laryng. 68:1069 (Dec.) 1959.

♦ Dr. Anthony, 705 Fifth Avenue, Fort Worth 4.

# *Foreign Bodies in the Gastrointestinal Tract*

*The alimentary tract has an amazing capacity for disposing of potentially dangerous foreign bodies. Swallowed buttons, tacks, pins, and other indigestible objects should be given ample time to pass naturally before surgical procedures are considered.*

J. Edward Johnson, M.D.

IN 1926 and 1927, the author was employed at Terrell State Hospital and was in charge of the x-ray department and the small hospital for acute diseases. Equipment included the best x-ray diagnostic equipment available at that time.

One morning a staff psychiatrist sent over for x-ray a 17 year old girl who had schizophrenia. She said there was a needle in her wrist. The psychiatrist suggested that fluoroscopic study of the abdomen be made as well because she had told her attendant that she had swallowed some pins.

The needle was visible beneath the skin on the volar surface of the wrist, with its eye next to the heel of the palm and its shaft directed toward the elbow and parallel with the radius. From the position, it was thought that the patient had started inserting the needle into the skin with her fingers and had completed the operation by pressing the eye against some hard object. When removed, the needle was encrusted with rust, which indicated that several weeks had elapsed since it was embedded in the flesh.

Fig. 1* shows what was seen at the fluoroscopic examination of the patient's abdomen. Investigation revealed that attendants usually kept a tray of pins

**Fig. 1.** This film shows the nature and location of various foreign objects in the patient's intestinal tract at the first examination.

*These roentgenograms were kept for many years and thus were in poor condition. Mr. F. W. Schmidt, photographer at the University of Texas Medical Branch, Galveston, restored them for reproduction.

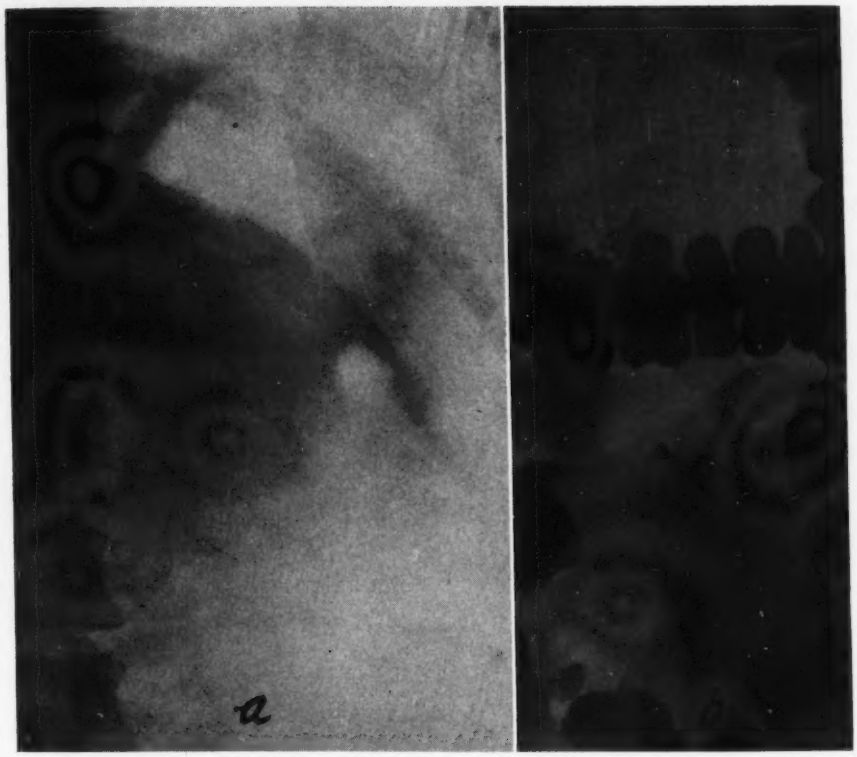


**Fig.2a.** After three weeks, one safety pin still was above the diaphragm, but two swallows of barium carried the top pin into the stomach. **b.** One day later both pins were in the small intestine.

on their desks for emergency use to replace missing buttons on women's dresses. The patient had been stealing these pins and swallowing them. She was an attractive, well developed young woman but was hopelessly psychotic, and never would give an explanation for her conduct. She was obviously healthy, and if the hardware diet caused any discomfort, she gave no sign of it.

No treatment was given, but the patient was isolated from the supply of foreign objects, and was placed under strict observation. Her stools were collected and strained. The nurses recovered as many as 90 pins in one 24 hour period. No bleeding or pain occurred.

After a 3 week delay (to avoid danger of too much radiation), the roentgenogram in fig. 2a was made. One of the safety pins was above the diaphragm, hence probably was still in the esophagus. One swallow of barium lowered the position of the pin, and the second carried it into the stomach. The following day it was seen in the small intestine, along with its companion (fig. 2b). Attendants insisted that the patient had stolen these pins from patients' dresses as she marched behind them to meals. With her previous record for normal disposal of pointed metallic objects, final passage of the cargo was left to Mother Nature.

Fig. 3 exhibits the array of objects swallowed by the second patient, an older woman. Clinical charts and roentgenograms show that she passed these foreign bodies without harm to herself, and required no medical or surgical intervention.

For years the author kept these pictures to show frightened mothers whose children had swallowed pennies, buttons, tacks, and pins. One mother was greatly relieved after seeing them. Her young son had just swallowed a small chickenwire staple. She was persuaded to take him home and to watch his stools for a few days. She reported recovery of the staple in about 3 days.

Medical journals have reported surgery done in early stages of passage of such pointed objects, without a reasonable period of observation to see whether they would pass normally. If a surgeon impulsively operates to remove an object from the stomach, he

**Dr. J. Edward Johnson prepared this paper shortly before his death December 17, 1960. A specialist in internal medicine, he practiced in Austin. Active in several medical organizations, Dr. Johnson also wrote numerous articles for the *Texas State Journal of Medicine*.**

may find that the exposed stomach no longer contains the object. To his chagrin, it may be recovered from the stools a few days later. Children have been operated on for a single straight pin that had passed all but the rectal sphincter without difficulty.

The surgeon, pressed by anxious relatives, often has not been able to restrain himself long enough to see whether normal passage of a foreign body would be accomplished. Experience taught the older doctors at Terrell State Hospital and other mental institutions that almost anything that passes the esophagus eventually can be recovered in the stool if patient vigilance is observed. In the cases presented, conservative measures allowed time for the alimentary tract to demonstrate its marvelous capacity to protect itself against errors in human judgment. The esophagus undoubtedly is the most dangerous area. Fortunately, if an object lodges there, symptoms will indicate danger, and removal by instruments usually obviates the necessity of laparotomy.

**Fig. 3.** All objects shown in this roentgenogram subsequently were passed without medical or surgical intervention, and without harm to the patient.

Dr. John E. Johnson, Jr., University of Texas Medical Branch, Galveston, son of the author, will accept orders for reprints.

## Professional Prescription?

"If you are not willing to learn and unlearn all your life through, you should give up medicine and take up a third-rate trade."

—Lord Lister.

"Learning is difficult enough, unlearning and relearning is not only difficult but is opposed by habit and false pride. It is nevertheless the price to be paid if you wish to be a worthy member of a learned profession."

—David Whitteridge, Learning and Relearning.

# REGIONAL ENTERITIS

*Regional enteritis is difficult to diagnose because symptoms are so similar to those of other conditions. Management, both medical and surgical, is described, and the literature is reviewed.*

Gordon McHardy, M.D.

REGIONAL ENTERITIS is considered a disease of recent recognition. Crohn and associates,[1] in 1932, focused attention on this bizarre entity, which was described pathologically by Morgagni[2] in 1761. Initially, the description was limited to the terminal ileum. Removal of this restriction, with recognition of other characteristics of the disease, created a series of connotations including regional ileitis,[1] chronic cicatrizing enteritis,[3] nonspecific granuloma of the ileocecal region,[4] chronic regional enteritis,[5] terminal ileitis,[6] distal ileitis,[7] localized hypertrophic enteritis,[8] segmental enteritis,[9] regional cicatrizing enteritis,[10] jejuno-ileitis or ileojejunitis,[11] ileocolitis,[12] ileitis with segmental colitis,[13] stenosing ileitis or enteritis,[13] and chronic ulcerative enteritis.[14] These connotations originated from occurrence of the disease in almost every portion of the mesenteric small intestine, involvement of several concomitant segments with apparently normal intervening intestine ("skip areas"), extension of ileal disease into the cecum, and concurrent existence of the condition in ileum and jejunum.

Identical distinguishing pathologic involvement has been described for localizations at all extremes from the esophagus to the ileocecal area. More frequent origin and localization in the terminal ileum alone justifies adherence to Crohn's[15] concept that regional enteritis (terminal ileal localization) is a distinct entity.

Crohn and Yarnis[16] have defined regional enteritis as ". . . a nonspecific chronic, recurrent, granulomatous disease, affecting mainly young adults, and characterized by a necrotizing, ulcerating inflammatory process, one in which cicatrizing elements in the long enduring cases are an important feature."

## Incidence

The first series reported by Crohn and associates[1] included 14 cases; in 1958 in the monograph by Crohn and Yarnis[16] 676 cases were studied. In a report in 1954 from the Mayo Clinic, 600 cases were reviewed.[17] The impression given by these figures that an abundance of cases is available for study is erroneous. Of 88 patients in the present survey, 26 had seen consultants at each of these institutions, as well as at the Lahey Clinic. Since, therefore, many of these cases and those of other reports are acknowledged duplications, no estimate can be made of the number of new patients that are being seen or of the incidence of the condition in the general population. In the author's Section on Gastroenterology, an average of 3 new patients with regional enteritis has been seen annually from a new clinic population averaging 2,500 annually. A survey of incidence of the disease in the Veterans Administration Hospital population is under way.[18]

Prevalence in the Jewish race has been recorded;[13, 19, 20] 34 of the author's 88 patients were Jewish. Crohn and Yarnis[16] consider the disease rare in the Negro, but Loria's[21] report has disproved this concept. The disease has been discovered in all races.

Climatic influence has been suggested by Bockus,[13] who found no evidence of the disease in Latin America. Recent publications disprove this, however.[22, 23] Crohn[16] noted a general distribution in his survey.

Hereditary factors are not dominant, but familial incidence has been mentioned,[1, 5, 13] with the suggestion of a constitutional tendency.[24] Occurrences in related Jewish persons have been observed in the author's clinic. Chronic ulcerative colitis was diagnosed in the immediate families of 16 of 88 patients in the present study.

This disease is more common to youth. The average age in the series reported by Crohn and Yarnis[16] was 27.6 years, with extremes of 9 months and 74 years. In the author's study, the youngest patient was 7 months old, the oldest 65 years, and the average age 26 years. Cicatrizing enterocolitis has been reported in the newborn.[25] In the Mayo Clinic series, the age at onset ranged from 4 to 74 years.[26]

Predominance in the male sex has been suggested.[13, 27, 28] The present series included 46 male and 42 female patients, a distribution which approaches the equal distribution by sex reported by Clark and Dixon.[29]

## Etiology

Some authorities have suggested that obstructive lymphedema is primary and that it results from progressive lymphoid hyperplasia[30] or granulomatous lymphangitis.[31] Crohn,[27] however, considered such an occurrence secondary. The etiology of this obstructive phenomenon remains unknown.

Most discussions of etiology have been devoted to elimination of proposed possible relationships. Tuberculosis has been discounted.[17] Syphilis can be eliminated by serologic tests, and actinomycosis can be differentiated by histologic examination. Histologic compatibility with Boeck's sarcoid has been denied by limitation.[20] Protozoal disease has occurred concomitantly, but without causal relationship. Johne's disease[32] of cattle and porcine disease[33] are not compatible with the occurrence in human beings. A bacterial cause could not be established by Pumphrey.[34] Viral infection has been proposed as a likely possibility by Crohn and Yarnis,[16] but among viral possibilities, only that of lymphopathia venereum has been eliminated.[35-37] Allergy has been suggested by Tallroth,[38] and absorption of talc and silica has been implicated experimentally.[10, 39, 48] Faulty lipoid absorption has been considered in an inconclusive study.[41-44]

An outstanding causal relationship to trauma has been supported by reports from the Mayo Clinic[45, 46] (2 cases), from ten Kate (2 instances),[46] from Spellberg and Gray (1 case),[47] and from Crohn and Yarnis (11 possibilities).[16] Five of the author's cases which occurred after severe automobile accidents supported the postulates of Crohn and Yarnis.[16] Nevertheless, whether cause or aggravation can be attributed to such accidents is debatable. An additional traumatic influence, self-rectifying intussusception or volvulus, has been proposed by Crohn and associates.[1] In the author's survey of this possibility in 18 such instances, the histologic observations have suggested regional enteritis.

The conjectural relationship to appendicitis, repeatedly mentioned in early descriptions, has lost credence with observation of the occurrence of enteritis distal to the appendix and in persons who have had appendectomy. Since the cause is unknown, the psyche has been incriminated.

The presence of aberrant or metaplastic pyloric glands in areas of regional enteritis has been reported.[48, 49] Such occurrence is not normal to the ileum, nor is it seen in the altered intestinal response to tuberculosis, postradiation enteritis, or neoplasm.[50]

## Pathologic Anatomy

The pathologic mechanism has been said to originate in lymphoid hyperplasia[30] or granulomatous lymphangitis[31] (primarily submucosal), obstructing lymphatic vessels of the intestinal wall and resulting in submucosal lymphedema, mucosal ulceration, secondary bacterial involvement with intramural abscesses, fistula formation, and stenosis.[51] Noncaseating giant cell systems devoid of acid-fast organisms are obliterated by diffuse inflammatory hyperplasia. In earlier stages, the regional nodes inhibit discrete giant cell systems, which regress without caseation. In the later stages, concurrent with deep ulceration, subacute lymphangitis obliterates the giant cell system. Endarteritis obliterans and perivascular infiltration with plasma cells,[52] involvement of nerve tissue,[53] Brunner-like glands,[48] and increase in myenteric plexus ganglions[54] have been reported, but are not a constant component of the disease.[55] The diseased segment may be sharply demarcated, but often is graduated into areas of acute hyperemia, vascular engorgement, and plastic exudate. The related mesentery is thick and edematous with enlarged lymph nodes and well delineated, fiber-like lymph radicles. "Matting," free and walled-off perforation, formation of fistulas and of fibrotic and inflammatory adhesions are complications in advanced disease.

On section, the intestinal wall, primarily the submucosa, is thickened. In early and prestenotic segments, the lumen may be dilated, but contraction of a stenotic tube is more characteristic. The mucosa exhibits various complicating stages of longitudinal ulceration, primarily along the mesenteric border; polypoid hyperplasia; intramural communicating abscesses; and cicatrization. "Dead" areas and areas of chronic infection may evolve into a "healing stage." The exudative or inflammatory reaction may be replaced by a fibrostenotic process, in which the small caliber of the segment sinks into the mesenteric fat.

## Clinical Manifestations

Clinical manifestations include the signs and symptoms shown in Table 1.

TABLE 1.—*Clinical Manifestations of Regional Enteritis.*

| | |
|---|---|
| 1. Diarrhea | 15. Miscellaneous: |
| 2. Abdominal pain | a. Appendectomy scar |
| 3. Psychic manifestations | b. Malignant transformation |
| 4. Low grade fever | c. Nausea and vomiting |
| 5. Anemia | d. Intermittent constipation |
| 6. Loss of weight | e. Asthenia |
| 7. Rectal suppurative lesions | f. Malaise |
| 8. Fistula | g. Retarded growth and secondary sexual development |
| 9. Abdominal mass | h. Arthritis |
| 10. Obstruction | i. Clubbing of fingers |
| 11. Hemorrhage | j. Erythema nodosum |
| 12. Polypoid changes | |
| 13. Perforation | |
| 14. Blind loop syndrome | |

Although no definitive clinical picture characterizes regional enteritis in its entirety, periodic syndromes conform to progression of the disease. Bizarre combinations of the manifestations listed may be observed in conditions other than enteritis, necessitating diagnosis by exclusion or exploratory laparotomy.

1. *Acute abdominal distress (appendicitis) with peritoneal irritation:* Regional enteritis may be indistinguishable from acute appendicitis. Colicky pain and localized tenderness are often accompanied by a more pronounced febrile response (101 to 102 F.) in the former, however, and leukocytosis is not necessarily concomitant. A mass is more frequently evident with regional enteritis, and diarrhea, a rarity with acute appendicitis, is common.

2. *Chronic ulcerative colitis:* In regional enteritis, the pain is in the lower abdominal or periumbilical region, with diarrheal tendency. It is seldom accompanied by tenesmus, however, unless rectal complications coexist, or by gross melena. Delayed gastroenteric reflex stimulation of pain and diarrhea, asthenia, anemia, and nutritional deficiency occur as the disease progresses.

3. *Chronic partial obstruction:* Most clinical diagnoses are made during the phase of partial obstruction. Nausea and vomiting are uncommon, and occur only in acute edematous or late stenotic phases of disease. Obstructive symptoms of varying severity, depending on location and degree of stenosis, are characteristically incomplete, and a mass is evident.

4. *Fever of undetermined origin:* Although fever is commonly mentioned, the author has seldom found it in patients with regional enteritis. Bockus[13] reported an instance of the condition misdiagnosed as "fever of undetermined origin." The duration of the disease before recognition (4.1 years),[29] the frequency of low grade fever (one-third of cases),[16] and the bizarre symptomatology or absence of other significant manifestations have resulted in such an inconclusive diagnosis in some instances.[13, 56]

5. *Gastrointestinal neurosis:* Certain aspects of regional enteritis may frustrate patient and physician alike: insidiousness with mild, persistent, or recurrent diarrhea; malaise; asthenia; and nervousness in patients with inconclusive or negative observations from roentgenographic examination. The indefiniteness of findings may cause the physician to conclude that the psyche has overwhelmed the soma. The frequency with which appendectomy has been performed without relief, but with indication of adequate exploration, supports this impression.[16] However, relationship of emotional cause and effect is rarely elicited.

6. *Complications:* The complications of regional enteritis include perianal suppurative disease (intractable fistula), hemorrhage, abscesses, internal fistula, and free perforation.

7. *The blind loop syndrome:* Common to regional enteritis, this condition often escapes detection because of manifestations that simulate the parent disease. A segment of intestine communicating with the fecal stream, which fills but empties incompletely is the site of significant constant or intermittent stasis. Such an area may be created in the dilatation of the loop proximal to stricture by spontaneous fistulas and, more significantly, by side-to-side surgical anastomosis and an exclusion procedure.

This syndrome may have a variety of manifestations:

a. Macrocytic megaloblastic anemia, which may be misinterpreted as anemia caused by loss of blood as a result of the parent disease.

b. Steatorrheal diarrhea, which may be construed as hypermotility malabsorption or irritability reaction of regional enteritis.

c. Localized ulceration in the blind segment with potential hemorrhage, perforation, or both.

All three possibilities conceivably are attributable to an abnormal bacterial population, and may result in: (1) loss of organisms which synthesize hemopoietic substance, or predominance of organisms

which consume hemopoietic material; (2) production of toxin, which interferes with synthesis or absorption of essential hemopoietic substance, especially vitamin $B_{12}$; (3) bacterial interference with absorption of fat; and (4) secondary infection of a diseased "static" segment of intestine, resulting in ulceration with its complications.

The response in each respect to chemotherapy supports the thesis that bacterial infection in a static intestinal segment is operative in the pathogenesis of the blind loop syndrome. Such therapy is only palliative, however, and proves the need for removal of the involved segment.

8. *Malignant transformation:* It has been postulated that adenocarcinoma may occur in "burned out" regional enteritis of long standing. The rarity of such reports (2 instances) warrants only mention of the possibility, however.[55, 57]

## General Symptoms

The general symptoms are bizarre. They may be those of an acute abdominal emergency, of functional motility or secretory disturbance, or of any chronic debilitating illness. Analysis of the present series of 88 cases showed relatively acute symptoms in 42 patients. A history of chronic disease, with manifestations beyond 4 years' duration, was elicited in 46 patients.

1. Exploratory laparotomy had been performed with surgical diagnosis in 38 patients. Acute abdominal disturbances were misdiagnosed preoperatively as acute appendicitis in 33 of these patients, Meckel's diverticulitis in 2, ectopic pregnancy in 2, and obstruction of the small intestine in 1. A presumptive diagnosis of regional enteritis had been recorded in 4 instances. Retrospective analysis showed a history of diarrhea in 34 patients, absence of significant leukocytosis in 16, a palpable mass in 11, and afebrile state in 22, and suggested that diagnosis had been too spontaneous.

2. Obstructive phenomena were definite in 23 patients. A correct preoperative diagnosis was ventured in 19 cases. In 4 instances, the presence of a neoplasm was presumed. All of these patients had intermittent diarrhea. A blind loop syndrome was established retrospectively in 8 cases.

3. Massive hemorrhage (cherry red rectal bleeding) occurred in 3 patients. In 2, regional enteritis was diagnosed preoperatively; in the third case it was suspected. All patients had intermittent diarrhea.

4. Ten patients had fistulas. Three of these lesions were incisional, resulting from drainage of an abscess; 4 were spontaneous intestino-intestinal; and 3 were perianal. All but 2 patients had diarrhea. The diagnosis was missed in only 1 patient.

**Dr. Gordon McHardy is from the Departments of Medicine and Surgery, Browne-McHardy Clinic, Louisiana State University School of Medicine, and Touro Infirmary, New Orleans, La. He presented this paper at the Twelfth Annual Stoneburner Lecture Series in Richmond, Va., March 13, 1959, and also before the General Meeting of the Texas Medical Association in Fort Worth on April 12, 1960.**

5. Perforation occurred with localized peritonitis and formation of abscess in 3 patients. A preoperative diagnosis of regional enteritis was made in 1 such case.

6. Eight patients were admitted with unexplained anemia; all had diarrhea. In 2 of these, the hematologic findings were compatible with the diagnosis of macrocytic megaloblastic anemia resulting from the blind loop syndrome.

7. An impression of psychosomatic disease had been given by the physician in 49 of the 88 patients.

8. Loss of weight was significant in only 16 of the patients with chronic disturbances. Five patients with protracted illness were excessively obese.

9. An abdominal mass was demonstrable in 11 of the patients with acute disease and in 29 with chronic difficulties.

10. Only 2 instances of polypoid change were seen, and none of malignant transformation.

## Radiologic Diagnosis

Careful radiologic study is of the utmost importance in evaluating the nature and extent of a lesion of the small intestine, when this is demonstrable. A barium enema should be given before examination of the upper part of the gastrointestinal tract in every instance of suspected obstruction; retrograde filling of the terminal ileum may permit conclusive diagnosis of disease in this area. In some instances obstructive phenomena may make use of Hypaque preferable to barium; in the author's experience, however, barium studies of the small intestine have been adequate and without complication.

Crohn and associates[1] in their initial discussion of regional enteritis summarized the roentgenographic findings as a barium enema with negative findings and a small bowel study with positive results. They depicted the obstructive findings of an ileal lesion with delayed motility (9 hours). Kantor[58] described the "string sign" that results from the stenotic lesion.

Finkelstein[59] indicated the limitations of roentgenographic examination; a negative result has little significance, especially in the nonstenosing type of lesion. He described the characteristics of the mucosal pattern in this group: "striking nodularity," loss of mucosal pattern, stiff configuration, separation of loops, and irregular marginal outline. At times, the disturbed mucosal pattern is interpreted as being characteristic of a nutritional deficiency disease, with flocculent or granular distribution of the barium.

The stenotic phase has some degree of diagnostic specificity on the roentgenogram. Characteristically, it is seen as a long stenotic segment with a moderately dilated but stiffened proximal bowel.

A smooth, symmetrical, biconcave defect on the medial aspect of the cecum above and below the ileocecal stoma is considered specific for ileocolitis or terminal ileitis. It is produced by extrinsic pressure of a thickened mesentery.

Recurrences of regional enteritis may mimic the original lesion. Complicating fistulous tracts and perforation, when demonstrable, present no diagnostic problem. They are characteristic, but demand differentiation, primarily from neoplasms.

Marshak[60] has provided the most complete summarization of radiographic data in this disease. He distinguished two roentgenologic descriptive classes by one of the most prominent and characteristic features, that is, the presence or absence of stenosis.

Early mucosal alterations that are demonstrable on the roentgenogram in regional enteritis include:

1. Blunting, flattening, and thickening of valvulae conniventes.
2. Arrangement of folds in symmetric, parallel fashion.
3. Fusion of folds.
4. Evidence of mucosal and submucosal thickening, emphasized in tendency of segments to be straightened and rigid.
5. Longitudinal streak-like ulcers.

Progressive mucosal destruction is evident on the roentgenogram by cobblestoning, an indication of partial mucosal desquamation and irregular denudation of mucosa with undermining. Interlacing of barium streaks produces a reticulated appearance.

Advancing changes are interpreted sequentially as: (1) smooth areas of incomplete mucosal denudation, (2) areas of luminary narrowing by cicatricial changes, (3) rigidity of contour, with cast-like appearance and complete absence of mucosal pattern, and (4) progression to stenosis.

Frequently, also, the barium mixture appears to remain fluid and homogenous, and "skip areas" of diseased segments are seen.

## Diagnosis

In most instances a presurgical diagnosis will be speculative. A classic case for roentgenographic confirmation would be the febrile, asthenic, Jewish male youth with previous appendectomy; with a right abdominal mass which, although fixed, is ill-defined; and with chronic diarrhea, yet distention. If the case is complicated by fistula, loss of weight, and anemia, a conclusive diagnosis is justified.

The Frei test should be done to exclude lymphogranuloma venereum, and the possibility of tuberculosis should be eliminated. Neoplasia should be excluded, especially lymphosarcoma, Hodgkin's disease, carcinoidosis, and sarcoidosis. Sprue, ulcerative colitis, diverticulitis, amebiasis, endometriosis, enterogenous cysts, lipodystrophy, pancreatic disease, and actinomycosis should be considered in the differential diagnosis.

The diagnosis, according to Crohn and Yarnis,[16] ". . . is essentially a clinical one, based upon the characteristic subjective symptoms and the physical findings. . . . Ileitis has clear-cut subjective and physical features, which, when combined, spell out a succinct clinical diagnosis." This conclusion, however, was based primarily on a study of referred cases, in which the task was usually confirmatory.

Meticulous survey of patients with chronic diarrhea, with alert observation for early manifestations of regional enteritis, will permit a presumptive diagnosis in most instances. The definitive diagnosis requires evaluation of pathologic changes observed during operation.

## Prognosis

It is hardly feasible to prognosticate when such uncertainties as these are inherent in the disease:

1. Undetermined etiology.
2. Acute exacerbations of undiagnosed chronic illness, readily misinterpreted as an acute phase.
3. Variable, but protracted, chronicity.
4. Clinical responses not consistently accompanied by comparable evidence of improvement on the roentgenogram.
5. Lack of adequate control studies to prove substantially the status of any medical or surgical program.
6. Reluctance to define "cure" without modification by "duration of cure," indicating the desirability of accepting the term "quiescent."
7. Residuals of physiologic and anatomic surgical alteration that are difficult to differentiate from recurrent disease.

"Quiescence" could best depict clinical improvement of variable degrees evidenced by gain in

TABLE 2.—*Results of Surgical Treatment of 68 Patients with Regional Enteritis (Six Year Follow Up Study).*

| Operation | Sustained Resolution | Acute Exacerbation | Chronicity | Re-Operation | Total No. Patients |
|---|---|---|---|---|---|
| Operation limited to exploration with or without appendectomy | 8 | 4 | 3 | 9 | 24 |
| Short-circuiting with exclusion | 3 | 5 | 8 | 12* | 28 |
| Resection | 2 | 3 | 6 | 5† | 16 |
| Total | 13 | 12 | 17 | 26 | 68 |

*1 death.
†2 deaths.

weight, favorable hematologic response, and relief of diarrhea and of abdominal discomfort with subsidence of acute inflammatory manifestations such as mass, fever, fistula, abscess.

Crohn and Yarnis[16] report 85 medically managed cases, with remarkable improvement in 66 cases. This gave a false impression of a large percentage of favorable responses, whereas these 66 cases actually represented only 12.2 per cent of the total of 542 cases in the series. Furthermore, the smaller group probably were the less serverely ill patients, whose condition had been quiescent longer than 3 years. Crohn and Yarnis,[16] in a report of cases classified as "failures of conservative management," favored short-circuiting over resection because of an assumed lower operative mortality rate (3.4 per cent as against 9.5 per cent), more favorable end result (67.7 per cent as against 57.8 per cent), and lower recurrence rate (29 per cent as against 32.7 per cent). Many factors in analysis of individual cases might appreciably alter such a conclusion, but this does not rule against the most conservative surgical attitude which, of course, must be based on surgical judgment at the time of exploration.

It is difficult to reconcile the recurrence rates of the Mayo Clinic (54.5 to 66 per cent)[17] and of the University of Pennsylvania[61] (58 per cent) with Crohn's estimate[16] of approximately 30 per cent. Crohn apparently considered that the higher incidence of recurrence resulted from overconservative delay. The author disagrees; in the present small series when either the short-circuit or resection procedure was postponed because of complications, fewer recurrences were observed. In the Mayo Clinic series,[26] one-third of the patients who had had definitive operation (resection) had no recurrence, whereas an equal proportion did.

In the present series, re-examination was restricted to 68 cases, all with surgical diagnosis and follow-up study for more than 6 years. Results of observations in these patients are shown in Table 2.

## Course of Disease

Spontaneous, permanent subsidence is infrequent. Durability of disease cannot be established with certainty, since recurrences have been observed after a delay of as long as 26 years, which is the duration of general interest in the disease.

Spontaneous quiescence, in which the disease remains localized but with episodes of acute or chronic exacerbation, represents an intermediary prognostic position, with a promising outlook for active life. Spontaneous or postsurgical progression is marked by disease of structures in contiguity, "skin" lesions; mild, insidious debilitating illness; severe, fulminating, devastating, cachexic disease; and such complications as free perforation, hemorrhage, formation of fistula, and obstruction.

Of the 68 patients who were re-examined, 37 are now gainfully occupied, 16 are active and self-sustaining but intermittently under medical care, 9 are dependent and debilitated, and 6 have died. Of the 6 deaths, 3 were independent of the surgical procedure and 3 a result of the operation.

Thirty-four of the author's patients required further operation, and the greater demand occurred after short-circuiting procedures. Obviously, as long as the cause remains hypothetical, therapy will be empirical and the prognosis poor in the patient who does not have a spontaneous remission.

## Management

The therapeutic program which evolved from individual study of patients consists of medical management when the disease entity remains uncomplicated with promise of relative stability, and surgical management in the presence of complications. Exploratory operation is justified because it is essential to definitive diagnosis. Appendectomy should be performed unless contraindication exists, because

subsequent manifestations may be indistinguishable from those of appendicitis.

The patient with uncomplicated enteritis should be treated medically because, despite the operative enthusiasm of Lahey and Sanderson,[62] the rationalization for operation is limited to complications of the disease. Medical therapy is tailored to control motility, nutrition, anemia, electrolyte balance, toxemia, and infection.

*Motility.* In the acute phases of the illness, a patient should be at complete bed rest with relative relief from emotional and physical disturbance. Graded activity with rest periods is permissible during recovery when fever is absent. Ingestion of meals in the supine position is advocated by some. Occasionally, opiates may be indicated for severe diarrhea, but they are best avoided for routine use because of the danger of addiction. Sedation and administration of hydragogues and antispasmodic and anticholinergic drugs are supplemental. Recent, but limited, experience has suggested that the anticholinergic Entostat and a demerol derivative, possibly nonaddicting, Lomotil, are more effective than agents previously employed. Of the absorbents, Sorbogel has proved most promising in 4 recent case studies.

*Nutrition.* An adequate, bland, low fat-high protein regimen is favored, with nonirritating supplements. Amino acids, plasma, vitamins (especially the fat soluble group), should be used, and all efforts should be made toward hyperalimentation. Parenteral administration may be imperative. Utilization of fat is poor, and intolerence to the substance great. A trial of saponifying products is justified, however. Attempts to force caloric intake by such preparations as Morcal and Sustagen have accentuated diarrhea and abdominal discomfort. Nilevar has not proved effective in the author's experience, but is favored by Ruffin.[63] Malabsorption in nonsurgically treated regional enteritis, after resection, and in association with the "blind loop" phenomenon, occurs because of impairment of function of the intestinal mucosa, hypermotility, and loss of absorptive surface. Its severity will vary with the loss of absorptive surface, but never is as pronounced as in the sprue syndrome. Other than in extensive disease or resection, it seldom has clinical significance other than subnutrition in prolonged illness. The primary absorption defects are demonstrable in relation to fats, fat-soluble vitamins, vitamin $B_{12}$, and electrolytes, especially calcium. Additionally, however, steatorrhea will result in depletion of proteins and carbohydrates in tissue. The therapeutic implication is that dietary components must be reinforced by all available tolerated oral and parenteral supplements.

*Anemia.* When anemia is caused by persistent loss of blood, replacement of blood is indicated. Oral iron preparations other than Simron are tolerated poorly, but parenteral administration (Imferon) has proved effective. Hemoconcentration is not unusual in view of dehydration phases, and always must be evaluated.

*Electrolytes.* In severe and complicated phases of regional enteritis, loss of fluid electrolytes may necessitate reasonable exactness in replacement of electrolytes, along with attempts at fluid balance. The problem is complex in cases recurrent after extensive resection, and may require such extremes as intragastric infusion of an osmotic formula for maximal absorption without the danger of producing hyperalimentation diarrhea.

*Toxemia and Infection.* Chemotherapy in the form of Azulfidine, and antibiotics in the form of penicillin-streptomycin combinations, are indicated for control of secondary infection. The broad spectrum agents should be reserved for pre- and postsurgical management and for perforation. In the case of sensitivity reaction to Azulfidine, the author has substituted Salazodimidin and found it equally satisfactory. Steroid therapy probably is of distinct value in the acute febrile phases of the disease with severe intoxication. Oral steroids usually are not as dramatically effective as parenteral ACTH on such occasions. They are applicable to general supportive care and as a part of the preoperative management of the debilitated patient, however.

*Roentgenotherapy.* Bargen's[64] experience with roentgenotherapy in 150 patients is impressive. Either remission or obstructive healing occurred in response to small doses of exposure to radiation.

*Other Measures.* Other adjunctive medical measures are physiotherapy, heliotherapy, and administration of testosterone for anabolic influence, of calcium, or of antihistamines. Psychotherapy has also been advocated. Rowe and associates[65] have recommended investigating and treating patients from the viewpoint of an allergist. Medical complications must be anticipated, such as hypochloremia, hypoestrinemia, acidosis, hypoproteinemia, anemia, nutritional edema, and hypovitaminosis. Decompression of the small bowel should be used to support the patient when there are obstructive manifestations, such as edema.

*Surgical treatment* is reserved for intractability, severe progressiveness, or complication. Relief and not cure is anticipated. Operative procedures advocated are one of the following:

1. One stage extensive resection with enterocolostomy.
2. Two stage resection with use of an initial short circuiting procedure, with or without transection of the small intestine; after an ill defined period, resection is employed.

3. Simple enterocolostomy as a short circuit procedure, with or without transection of the small intestine.
4. Transthoracic bilateral vagotomy[66] as a potential control measure for related hypermotility and diarrhea. Only transient improvement in excretion of fat and nitrogen was achieved in experimental observations.
5. Surgical mucus ileostomy or colostomy, or both. Such measures may be imperative in the "blind loop syndrome" or when resection of the involved segment surgically is not feasible as a palliative measure.

The desirability of ileal transection in short-circuit procedure has been emphasized.[16] Avoidance of side to side anastomosis, with its tendency to create "blind loops," is a recognized surgical precaution.

It is the author's impression that surgery is diagnostic and that it offers a mode for symptomatic relief and rehabilitation. Surgery, however, should not be considered as an absolute cure. The mortality rate is expectedly low regardless of the procedure, but recurrences are the same regardless of the operative approach. Recurrences are considered the result of progression of the disease, and not of the type of surgery used. In the author's experience, complications are more common to shunt procedures and often necessitate resection.

---

A complete reference list may be obtained from Dr. McHardy, Browne-McHardy Clinic, 3636 St. Charles Ave., New Orleans 15, La.

---

# Camps for Handicapped Increased This Summer

The fun of camping will be available to many more crippled children and adults this summer.

More than 50 new resident camps and a substantial increase in the number of day camp programs are revealed in the revised edition of *Directory of Camps for the Handicapped,* published by the National Society for Crippled Children and Adults, the Easter Seal Society.

Prepared by the Society under joint sponsorship of the American Academy of Pediatrics and the American Camping Association, the directory supplies up to date information on approved camping programs and facilities, from which parents of handicapped children, professional workers, and crippled persons can select programs.

The directory is available at 50 cents per copy through the National Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago 12.

*Cutaneous larva migrans can be an acute inflammatory cutaneous disease. A syndrome of transient pulmonary infiltrate and blood eosinophilia may be associated.*

# Cutaneous Larva Migrans Associated with Loeffler's Syndrome

## Report of a Case

Hugh S. Falconer, M.D., and Walker A. Lea, Jr., M.D.

CUTANEOUS LARVA migrans (creeping eruption) applies to a number of acute inflammatory diseases of the skin characterized by migrating, serpiginous, elevated lesions which are intensely pruritic. Most frequently, lesions occur on the feet, toes, buttocks, and genitals. This condition is more common in the Caucasian than in the Negro race.[20]

In the United States most cases are found in the southeastern and Gulf Coast regions.[21] A few have been reported as far north as Massachusetts.[26] Sandy beaches and sand boxes often harbor the infectious organisms. Plumbers, termite eradicators, electricians, and other persons whose occupations necessitate bodily contact with the ground usually develop extensive lesions of creeping eruption.[43]

Cutaneous larva migrans may be associated with Loeffler's syndrome. The purpose of this paper is to report such a case and to briefly review the literature.

### Review of the Literature

In 1926, Kirby-Smith, Dove, and White used the term "creeping eruption" to describe a skin disease characterized by a linear, tortuous, and serpiginous eruption.[28] Later, White and Dove[41] demonstrated the etiologic agents of this disease. They noted nematode larvae in the skin of patients with cutaneous larva migrans and identified the parasites as Ancylostoma braziliense, the dog and cat hookworm. By the application of nematode larvae to the unabraded skin, Shelmire[32] produced the lesions of creeping eruption in volunteers. He proposed the use of ethyl chloride spray in the treatment of patients with the cutaneous lesions. In 1937, Bonne[5] demonstrated nematode larvae and ova in the submucosa of the human intestinal wall of 5 patients. In 1 of these patients, the A. braziliense larvae were identified. Trichophyton rubrum infection closely simulated the eruption of larva migrans in the case reported by Weiner.[40]

**Dr. Hugh S. Falconer is a resident in internal medicine and Dr. Walker A. Lea, Jr., is from the Department of Dermatology, Scott and White Clinic, Temple.**

In 1932, Loeffler described a syndrome of transient pulmonary infiltrate and blood eosinophilia which he believed to be of tuberculous origin.[22] Since

the description, this syndrome has been attributed to an allergic response to various allergens including Entamoeba histolytica, Trichinella spiralis, Ascaris lumbricoides, brucellosis, and other agents.[11, 18, 33] Whether this is a reaction of the parenchyma of the lungs to allergens or to an unknown agent has to be determined.[21] The outstanding features of this syndrome include the triad of transitory pulmonary infiltration, blood eosinophilia, and an illness of a benign nature.[1, 10, 15, 21, 35] The histologic findings of Loeffler's syndrome were described by Baggenstoss and others[1] in 1946.

Wright and Gold[45] have reported 26 cases of Loeffler's syndrome associated with creeping eruption. In their patients, neither ova nor parasites was found in 204 stool examinations and 381 sputum examinations failed to demonstrate nematode larvae. These workers[44] were the first to describe a patchy, pulmonary infiltration associated with creeping eruption. Ham and Zimdahl[15] in 1948, reported 13 cases in which transitory pulmonary infiltration and blood eosinophilia were associated. Horton[19] and Kalmon[21] each reported a case associated with Loeffler's syndrome. A. braziliense ova were found in the fecal material examined by Kalmon. This suggested that the nematode larvae could circulate to the lungs to produce Loeffler's syndrome. In 1953, Muhleisen[28] reported a case in which filariform larvae were demonstrated in the sputum. Hookworm infection in the intestines did not develop in this patient. Berk[3] suggested that every patient having transitory pulmonary infiltration associated with eosinophilia should have stool and sputum examinations.

*Causative Agent.*—In this country most cases of creeping eruption result from penetration of the epidermis of man by A. braziliense.[8, 9, 16, 23, 26, 27] Larval stages of other species, Ancylostoma caninum, Necator americanus, Uncinaria stenocephala, Strongyloides stercoralis, Gnathostoma hispidum, Gasterophilus intestinalis, and Hypoderma bovis have been reported to produce this disease.[8, 9, 16, 26, 29, 37] Pillsbury[29] and other authors[37] have described the means of differential diagnosis between these conditions.

*Cutaneous Findings.*—After penetration of the epidermis by the larvae, stinging and burning may occur immediately, or the patient may not notice discomfort for several hours or days.[24, 26] A red papule which is intensely pruritic develops at the site of invasion, and migration of the larvae usually begins within 2 or 3 days.[2] These larvae may migrate 1 cm. or more in 24 hours. This migration is accompanied by intense pruritus. Burrowing may continue for days before crusting and drying of the lesion occur. Local treatment, applied too vigorously, frequently causes severe dermatitis. Rubbing and scratching often precipitate secondary infection.

## Methods of Treatment

*Topical Therapy.*—Topical therapy varies. Phenol, onion poultices,[14] ethyl acetate collodion,[43] ethyl chloride spray,[24] and carbon dioxide snow[16] have been used; however, none of these methods has proved adequate. The rationale for such measures is to form blisters and thus to remove the larvae from

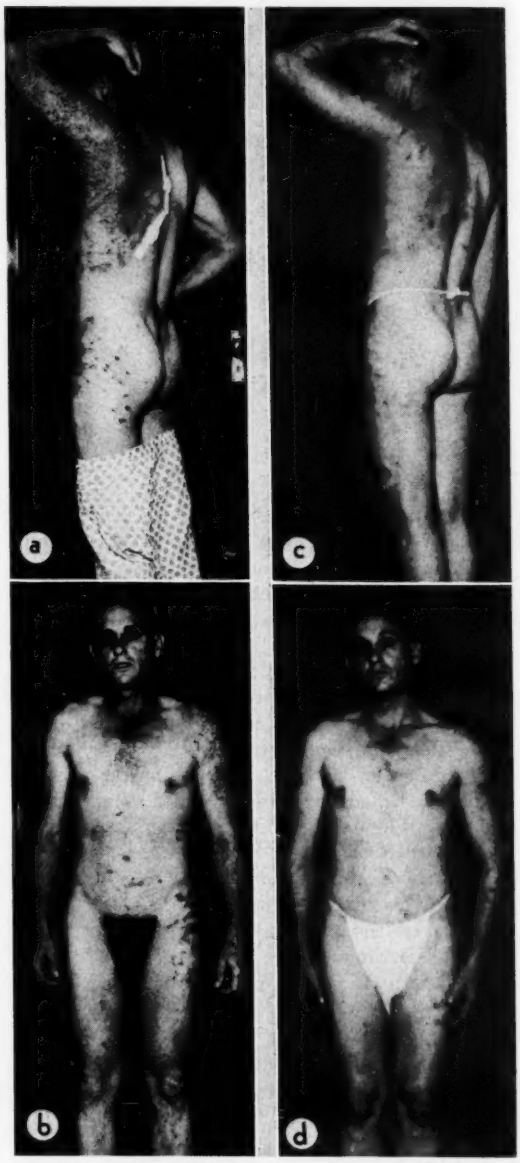



**Fig. 1 (a and b).** Photographs on hospital admission demonstrating active lesions of cutaneous larva migrans. **(c and d).** Photographs on dismissal showing that cellulitis had improved.

the layers of the skin.[42] Promising new methods of treatment include electrolysis[12] and vibrapuncture.[39]

*Systemic Therapy.*—In 1943, Fuadin was used.[34] Subsequently, contradictory reports have appeared.[4, 9, 17, 19, 25, 30, 31, 36, 39, 43] The use of diethylcarbamazine (Hetrazan) has been controversial.[20, 29, 38] Promising results using chloroquine were reported in 1956.[7] In 1959, Greene[13] used promethazine successfully in treating 57 patients. He noted, further, that this drug was more effective when the larvae were migrating through the skin. The effect of piperazine on A. braziliense is doubtful.[6]

## Case Report

A 37-year-old white man was admitted to the Gulf, Colorado and Santa Fe Hospital on September 21, 1959. His chief complaint was pruritic dermatitis localized to the left side of his body. The eruption had begun shortly after the man had been lying on moist ground while working under his house, and had been present for approximately two weeks. His local physician made a diagnosis of creeping eruption and prescribed antibiotics and various topical applications. Approximately 48 hours before admission to the hospital, the following symptoms developed: fever, nonproductive cough, pulmonary rales, nausea, and vomiting.

*Physical Findings:* Physical findings included tachycardia; tachypnea; moist, sibilant expiratory rales; and bilateral wheezing. Oral temperature was 102.4 F. on admission. Cutaneous changes were localized to the left arm, shoulder, buttocks, and thigh (Fig. 1a, 1b). Severe erythema and lichenification surrounded tunnel-like serpiginous lesions. In these areas cellulitis and excoriation were pronounced (Fig. 2a, 2b).

*Laboratory Findings:* On admission, the complete blood count showed: white blood cells, 18,300; hemoglobin, 14.5 Gm.; and red blood cells, 4,800,000 per 100 cc. The differential count showed 20 per cent eosinophils. Sedimentation rate was 79 mm. (Wintrobe).

The chest roentgenogram (Fig. 3a) showed patchy, poorly defined areas of increased density throughout both lung fields. Both hilar shadows were moderately enlarged.

In an attempt to demonstrate larvae, a skin biopsy was performed. The specimen was taken at the end of a serpiginous lesion and included both normal and diseased tissue. Larvae were not found in serial sections. Sputum and fecal examinations were negative for ova and parasites on four occasions, but one sputum examination revealed eosinophilia, 2 per cent. Cold agglutinations were reported as negative. Urinalysis was not remarkable.

*A diagnosis of cutaneous larva migrans with secondary cellulitis and Loeffler's syndrome was made.*

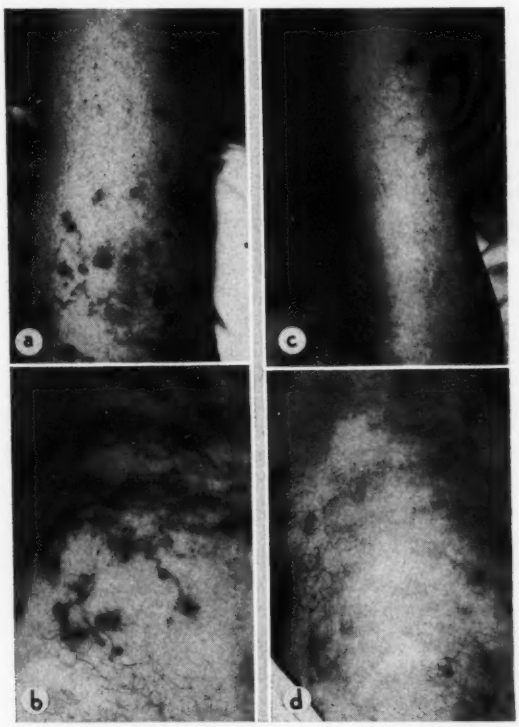



**Fig. 2 (a and b).** Photographs on admission demonstrating pronounced cellulitis and excoriation on arms and legs.

**(c and d).** Photographs on dismissal; only two active lesions of larva migrans remained.

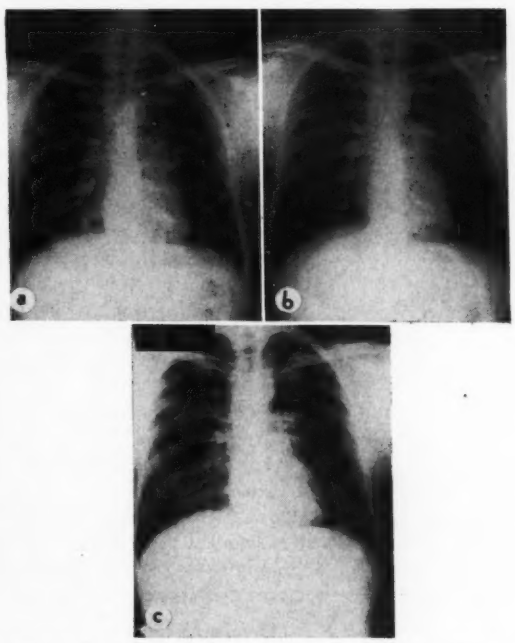



**Fig. 3 (a).** Chest roentgenogram on admission; patchy, poorly defined areas of increased density were visible throughout both lung fields.

**(b).** On sixth hospital day; patchy infiltrate in lungs had resolved considerably.

**(c).** Chest roentgenogram on ninth hospital day revealing normal findings.

*Hospital Course:* After his admission to the hospital, the patient's oral temperature rose to 103 F. Oxygen therapy was administered to facilitate breathing. Tetracyclines were administered orally. Triamcinalone therapy was begun on the second hospital day. Supportive therapy included intravenous fluids, oral salicylates, antihistamines, and sedatives. Diethylcarbamazine was administered for its specific effect on the larvae. In an attempt to eradicate the larvae, carbon dioxide snow was used at the terminal end of the serpiginous burrows. Local treatment included use of antipruritic lotions and aluminum subacetate wet dressings. On two occasions superficial roentgen therapy was employed to diseased areas in an attempt to relieve pruritus. The patient required large doses of sedatives, and upon several occasions, narcotics were needed to relieve the intense pruritus.

After 36 hours, the patient's temperature and breathing became normal. The complete blood count continued to show an extremely high white cell count (23,000 to 10,300), with eosinophilia ranging from 59 to 46 per cent. The sedimentation rate was within a normal range (8 mm.) by the thirteenth hospital day.

On the sixth hospital day, a roentgenogram of the chest (Fig. 3b) showed considerable resolution of the patchy infiltrate in both lungs. Hilar shadows appeared within normal limits. By the ninth hospital day, a chest roentgenogram showed normal findings (Fig. 3c). At the time of the patient's dismissal on November 11, 1959, evidence of cellulitis had disappeared (Fig. 1c, 1d). When he was seen again in the out-patient department on November 28, he still had two active lesions of larva migrans (Fig. 2c, 2d). He was feeling well and had returned to work. On January 9, 1960, all lesions of cutaneous larva migrans had vanished.

Drs. Falconer and Lea, Scott and White Clinic, Temple, Texas.

*A bibliography can be obtained from the authors.*

---

# Presidents, Too, Are Living Longer!

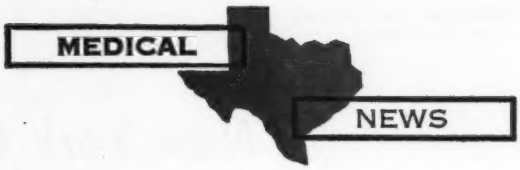
When President John F. Kennedy was sworn in on January 20, 1961, it was the first time in 75 years that three ex-presidents were alive for an inauguration. At that time, Dwight D. Eisenhower was 70, Harry S. Truman was 76, and Herbert C. Hoover was 86.

Since the Civil War there have been only two other Presidents—Grover Cleveland and William H. Taft—who have outlived their expectation of life at inauguration. The 15 deceased Presidents from Lincoln to Franklin Roosevelt lived about eight years less, on the average, than expected.

John Adams was the longest-lived of our Presidents, attaining age 90, or 16 years in excess of his expectation of life at inauguration. Garfield, dying from an assassin's bullet at the age of 49, was the shortest-lived.

Theodore Roosevelt was the youngest at inauguration, 42 years of age; Kennedy was 43. Oldest men to become President were William H. Harrison and James Buchanan, who were 68 and 65, respectively, at inauguration.

Does being President shorten a man's life? They can't tell yet, report statisticians of the Metropolitan Life Insurance Company. There have only been 34 U. S. Presidents so far and their longevity record has varied from one historic period to another.




## *MEDICOLEGAL NOTES*

# Registration of Fetal Deaths

Periodically I receive inquires from physicians as to whether death certificates are necessary in fetal deaths, and if so, at what period of gestation.

Rule 39a of Article 4477 deals with the registration of fetal deaths:

"Subject to the regulations of the State Department of Health, a certificate of each stillbirth which occurs in this state shall be filed with the local registrar of the district in which the stillbirth occurred . . . Except as otherwise provided, the medical certification shall be made by the person in attendance at the stillbirth . . . The certificate of stillbirth shall be filed in the same manner as a certificate of death and a burial-transit permit shall be required."

Although the above statute is clear as to what is necessary in the way of registration of stillbirths or fetal deaths, it leaves much to be desired in regard to just what constitutes a stillbirth or fetal death. Consequently, the following regulation was promulgated:

"Fetal deaths means death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles."

Another area of concern to physicians, not covered by Rule 39a of Article 4477, is the question of whether a certificate of stillbirth is necessary when gestation terminates at an early stage. To clarify this point, the following regulation was enacted:

"A certificate of stillbirth (fetal death) shall be filed for any stillbirth (fetal death) if the period of gestation is twenty completed weeks or more."

In connection with previous regulation, the Bureau of Vital Statistics of the Texas Department of Health has taken the position that in determining whether gestation has been 20 completed weeks or more, such period should be measured from the first day of the last menstrual period. In the event the stillbirth or fetal death occurs before 20 completed weeks of gestation, registration of the fetal death is not required.

—Philip R. Overton, LL.B.

## Harris County Doctors Plan 1962 Health Fair

The Harris County Medical Society has voted to stage a Health Fair in Houston early in 1962, providing a medical showcase for the lay public.

Physicians will assess themselves to bear the cost of the Fair. The Society plans to invite exhibits by hospitals, school health departments, medical schools, pharmaceutical and chemical concerns, medical specialty groups, community health agencies, city and county health departments, and other auxiliary medical groups.

Two speakers dated by the Harris County group for its monthly meetings in March and April were New York psychiatrist Dr. Lewis R. Wolberg, who attracted a standing-room-only audience, and Dr. Edward R. Annis, Miami surgeon who has become nationally-known for his television debates with Walter Reuther.

# New York City to Host AMA Session June 25-30

The American Medical Association's 110th annual meeting—the "world's fair of medicine"—will be held in New York City June 25-30. Featuring the theme, "Teamwork in Medicine," the convention will have a scientific program participated in by approximately 2,000 doctors and is expected to attract an estimated total of 50,000 persons, including 25,000 physicians.

The meeting will open formally on Sunday, June 25, a day earlier than has been customary at past conventions. Both registration facilities and technical and scientific exhibits will be open and staffed until 5 p.m. in New York's four-floored Coliseum.

Teaching mediums during the scientific sessions will include lectures, symposiums, panel discussions, movies, and closed-circuit television. Twenty section meetings, running simultaneously, will be held in the Coliseum and in the nearby Essex House, Barbizon Plaza, Plaza, Henry Hudson, and Sheraton-Park Hotels.

Highlight of the scientific program will be a one-day meeting on Monday, sponsored by the AMA and the American College of Chest Physicians, which is also holding its own 27th annual meeting in New York June 22-26.

### New Research Forums Slated

Tuesday, Wednesday, and Thursday, the AMA will sponsor for the first time a Multiple Disciple Research Forum. Participants will represent a cross-section of every medical specialty. "Newest and most up-to-date knowledge in man's never-ending fight against disease will be covered from every conceivable angle, opening new vistas for the busy practicing physician," says Dr. John B. Youmans, director of the AMA Division of Scientific Activities, of the Forums.

The AMA Section on Otolaryngology will sponsor instruction courses on surgery of the ear, the nose and sinuses, and the throat during three Thursday sessions (each limited to 50 attendance). High blood pressure due to kidney diseases will be the topic of a combined meeting of the AMA Sections on General Practice, Urology, General Surgery, Internal Medicine, and Pathology and Physiology on Wednesday morning. Wednesday afternoon a similar session dealing with diseases of the colon will be held by five sponsoring sections, Preventive Medicine, Gastroenterology and Proctology, Radiology, Pathology and Physiology, and Surgery.

The AMA Section on Surgery and the Section on Physical Medicine will meet with the American Rheumatism Association in the Coliseum on Thursday with an entirely new program format. The program, concerned with rheumatoid arthritis, will include a symposium, lecture, motion picture, and live color television. On the same day, the Section on Surgery will sponsor a television program showing the various new chemical treatments for cancer of the bowel.

### Largest Fresh Tissue Exhibit Set

Visiting physicians will be able to view and study the largest and most unusual collection of fresh tissues ever assembled at a medical meeting. Contributing to the exhibit are all New York hospitals.

An expanded physical examination booth for all physicians will be on the Coliseum's third floor. Here doctors can obtain heart, chest x-ray, and eye examinations. Next door will be a modern laboratory for urinalysis and blood studies.

More than 50 films will be shown during the five day meeting. Most outstanding film feature will be the second U. S. International Medical Exhibit, a series of outstanding medical films from other parts of the world. Other films will deal with medical missionary activities in foreign countries, with external heart massage, and with new developments in treatment of coronary heart disease.

More than 350 scientific exhibits largely developed, designed, and manned by physicians reporting their research—plus 827 technical exhibits displaying everything from medical books to diapers—will take up almost all four floors of New York's mammoth Coliseum.

### House of Delegates Convenes Monday

The House of Delegates, policy-making body of the AMA patterned after the U. S. Congress, will

meet at the Statler-Hilton, headquarters hotel, at 10 a.m. Monday.

Representing the Texas Medical Association will be its eight delegates: Dr. Troy A. Shafer, Harlingen; Dr. John K. Glen, Houston; Dr. G. W. Cleveland, Austin; Dr. James H. Wooten, Columbus; Dr. T. C. Terrell, Fort Worth; Dr. M. O. Rouse, Dallas; Dr. J. B. Copeland, San Antonio; and Dr. J. C. Terrell, Stephenville.

First item of business by the House will be selection of the recipient of the AMA Distinguished Service Award, given annually to the physician who has made an outstanding contribution to medicine.

Matters to be considered by the House will probably include:

(1) A supplemental report relating to closer cooperation between the American Medical Association, American Hospital Association, National Association of Blue Shield Plans, and Blue Cross Association in promoting "maximum development of the voluntary non-profit prepayment concept to provide health care for the American people."

(2) A report by the AMA Judicial Council, which will cover the controversial relationship between doctors of medicine and doctors of osteopathy.

(3) A status report by the AMA Commission on the Cost of Medical Care, which is presently studying all facets of the broad, medical care cost problem.

(4) A final report by a committee which has studied all mechanisms for disciplining members of the medical profession.

(5) Washington legislation, especially various aspects of President Kennedy's program for health care of the aged through social security.

#### North Dakotan to Become President

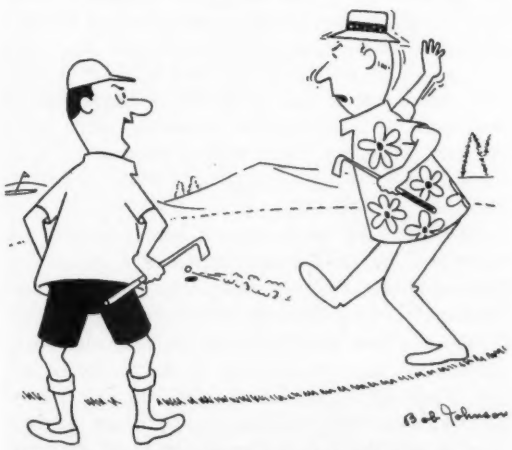
Dr. Leonard W. Larson, 63, pathologist and clinic executive from Bismarck, N.D., will be inaugurated as president of the AMA at 8:30 p.m. Tuesday in the Waldorf-Astoria Hotel ballroom. Feature of the inaugural ceremonies will be the appearance of the Montgomery County (Ohio) Medical Society Glee Club, made up of 45 practicing physicians. A reception and ball for the incoming president will follow the inauguration.

Approximately 3,000 members of the AMA Woman's Auxiliary will hold their 38th annual convention simultaneously with the AMA session. Headquarters of the women's group will be the Hotel Roosevelt. President and President-elect of the Auxiliary are Mrs. William Mackersie of Detroit and Mrs. Harlan English of Danville, Ill., respectively.

On the Tuesday of convention week, officers and trustees of the AMA and their wives will be guests at a luncheon honoring all past presidents of the Auxiliary. At this time, the Auxiliary will present its annual contribution to the American Medical Education Foundation; the group hopes to exceed its 1960 contribution of $175,000.

#### Medical Student Group Is Included

The president and vice-president of the Student American Medical Association will serve as ex-officio members of the AMA House of Delegates. The grand award winners in the student and intern-resident categories of the SAMA Scientific Exhibit at that group's May 4-7 Chicago meeting will be present with their exhibits in the AMA scientific exhibition area. Also, the writer of the best scientific paper presented during the May SAMA convention will deliver his paper as part of the AMA scientific program.



**"Explain again, Doctor, what that does to the adrenal gland!"**

## Laboratory Animal Panel Slates Boston Meet

The Animal Care Panel, an organization of individuals professionally engaged in the production, procurement, care, management, and use of laboratory animals and of institutions interested in these areas of research and animal care, will hold its 12th annual meeting September 27-29 in Boston. Attendance is expected to be 800 or more.

"Care of research animals is of utmost importance for the future of our research program and the entire health program," says Bernard F. Trum, D.V.M., member of the faculty, Harvard Medical School, and general chairman of the meeting. "All progressive medical centers will be represented at the meeting and problems of housing and handling research animals will be one of the primary topics for discussion."

# Medical Assembly Dates 18 Guest Speakers

The Postgraduate Medical Assembly of South Texas will hold its twenty-seventh annual meeting July 10-12 at the Shamrock Hilton Hotel, Houston. Included in the program will be symposia and panel discussions, four major section meetings, and presentation of many medical essays.

Guest speakers already scheduled to speak are Dr. Oscar J. Becker, associate professor of otolaryngology, Division of Maxillo-Facial Surgery, University of Illinois College of Medicine, and surgeon, Plastic Surgery Service, University of Illinois Eye and Ear Infirmary and Research and Educational Hospital, Chicago; Dr. Charles Howard Brown, head of the Department of Gastroenterology, Cleveland Clinic, Ohio; Dr. Paul D. Bruns, professor in the Department of Obstetrics and Gynecology, University of Colorado Medical Center, Denver; Dr. George Edward Burch, Jr., Henderson Professor of Medicine and Director of Cardiovascular Research Laboratory, Tulane University School of Medicine, New Orleans.

Also Dr. James Clarence Cain, associate professor of medicine, Graduate School of the University of Minnesota, and consultant in medicine, Mayo Clinic, Rochester, Minn.; Dr. Arthur Curtis Corcoran, assistant director of the Research Division, Cleveland Clinic, Ohio; Dr. Paul A. Chandler, associate clinical professor of ophthalmology, Harvard Medical School, Boston; Dr. Paul T. DeCamp, associate professor of clinical surgery, Tulane University School of Medicine, and member of the Ochsner Clinic Section on Thoracic and Cardiovascular Surgery.

Also Dr. Arthur Gerard DeVoe, director of the Institute of Ophthalmology, Presbyterian Hospital, New York City, and professor of ophthalmology, College of Physicians and Surgeons, Columbia University; Dr. James Henry Ferguson, professor and chairman of the Department of Obstetrics and Gynecology, University of Miami School of Medicine, and chief of obstetrics-gynecology, Jackson Memorial Hospital, Miami.

Also Dr. John Stirling Meyer, professor of neurology, Wayne State University School of Medicine, Detroit; Dr. Francis Murphey, professor of neurosurgery, University of Tennessee College of Medicine, Memphis; Dr. Nils G. Richtner, associate professor of otorhinolaryngology, Karolinska Institutet, and head surgeon of Sabbatasberg Hospital Ear, Nose and Throat Department, Stockholm, Sweden.

Also Dr. Henry William Scott, Jr., professor of surgery, Vanderbilt University School of Medicine, and surgeon-in-chief, Vanderbilt University Hospital, Graham, N. C.; Dr. Frank C. Spencer, associate professor of surgery, Johns Hopkins University School of Medicine, and John and Mary Markle Scholar in Medical Science, Baltimore; Dr. Howard J. Tatum, professor, Department of Obstetrics and Gynecology, University of Oregon Medical School, and professor, University of Oregon Medical School Hospitals and Clinics, Portland; Dr. Philip Duncan Wilson, Jr., assistant professor of clinical surgery, Cornell University Medical College, and associate attending orthopedic surgeon, New York Hospital, New York City; and Dr. E. R. Woodward, professor and head of the Department of Surgery, University of Florida College of Medicine; Gainesville, Fla.

Further information is available from the Assembly's Executive Office, 412 Jesse H. Jones Library Bldg., Houston 25.

## *Alcohol Institute Scheduled July 16-19 in Austin*

Marty Mann, executive director of the National Council on Alcoholism, New York City, and four other recognized experts will be guest lecturers when the Fourth Annual Institute on Alcohol Studies is held in Austin July 16-19.

The other speakers will include Dr. Felix Bambace, clinical director of the Adult Mental Health Clinic, San Antonio; Judge Ray Harrison of the Municipal Court, Des Moines, Iowa; C. Stanley Clifton, Ph.D., director of the School of Social Work, University of Oklahoma, Norman; and John Park Lee, secretary of the Department of Health and Welfare, Board of National Missions, United Presbyterian Church in the United States, New York City.

The Institute is held each year to provide a setting in which the helping professions can enhance their knowledge and understanding of alcoholism and acquire techniques which may be used in work with the alcoholic and his family. Subjects covered will be of particular interest to doctors, nurses, social workers, ministers, court and correctional officials, as well as civic leaders identified with interest in treatment and prevention of the disorder.

Enrollment for the Institute is limited to 200. Sessions will be held in air conditioned Kinsolving Dormitory on the University of Texas campus, where students will be housed and meals will be available.

Sponsors are the Texas Commission on Alcoholism and the University of Texas School of Social Work, Division of Extension, and Department of Health and Physical Education. Further information is available upon request from the Institute, State Office Bldg., Room 808, Austin.

## Medical Assistants Convene In Fort Worth May 19-21

Five Texas physicians are program participants in the fourth annual convention of the Texas Medical Assistants Association May 19-21 in Fort Worth.

They include Dr. May Owen, Fort Worth, immediate past president of the Texas Medical Association, who will install new officers of the group; Dr. M. O. Rouse, Dallas, who will discuss "The Physician and His Assistants as Citizens"; Dr. J. J. Andujar, Fort Worth, who will speak on "Medico-Legal Problems of the Medical Assistants"; Dr. Frank B. Gooch, Fort Worth, whose topic will be "Public Relations Is Your Business"; and Dr. R. W. Rasor, Fort Worth, who will discuss "Narcotic Addiction."

The convention program will include committee and business meetings, a session of the TMAA House of Delegates, lectures and tours at the Fort Worth Radiation Center and Carter Blood Center, educational forums, and a series of social events including a President's reception sponsored by Blue Cross-Blue Shield.

"Achievement Through Education" is the convention theme.

Only four years old, the Texas Medical Assistants Association functions with the support and approval of the Texas Medical Association and the American Medical Association. It has about 600 members.

Advisers of the organization are Dr. Everett C. Fox, Dallas; Dr. Frank B. Gooch, Fort Worth; Dr. C. Denton Kerr, Houston; Dr. John L. Matthews, San Antonio; Dr. Charles E. Ratcliff, Lubbock; and Dr. Albert A. Tisdale, Austin.

## Communicable Disease Courses Scheduled

A schedule of laboratory refresher training courses pertaining to communicable diseases is now available to physicians and other interested persons from the sponsoring Laboratory Branch of the U. S. Department of Health, Education, and Welfare's Communicable Disease Center in Atlanta, Ga. Courses listed are those to be open between September 11, 1961, and April 13, 1962.

Requests for the schedule, further information, or application forms should be directed to the Laboratory Branch of the Center, U. S. Public Health Service, Atlanta 22, Ga.

## Peaceful Space Use To Be May Conference Topic

The first national conference on the peaceful uses of space will be held in Tulsa May 26-27, when leading authorities in space science, medicine, and education, as well as top industry leaders and government planners, will participate. Attendance expected is over 2,000.

Sponsors of the meeting are the National Aeronautics and Space Administration and the Tulsa Chamber of Commerce, with co-sponsors to include the Aerospace Medical Association, Aerospace Industries Association of America, American Astronautical Society, American Institute of Biological Sciences, American Rocket Society, Frontiers of Science Foundation, Electronic Industries Association, and the Institute of Aerospace Sciences.

Major addresses will be made by Senator Robert S. Kerr, chairman of the Senate Aeronautical and Space Science Committee; James E. Webb, administrator of the National Aeronautics and Space Administration; and Harold C. Stuart, Tulsa attorney and former assistant secretary of the Air Force, who is conference chairman.

## Disaster Medical Care Session Set By AMA

"Defense Training for All—A Resource for National Defense" has been set as the theme for the ninth annual Conference on Disaster Medical Care in New York City June 24. Sponsored by the American Medical Association's Council on National Security, the theme of the one-day meeting at the Statler-Hilton Hotel will be developed by the United States Air Force Medical Service.

Major General O. K. Niess, surgeon general of the Air Force, will discuss the adaptability of military medical experience, research, and operations in civilian disasters.

Program topics will include such topics as "Nuclear War and Your Community," "Transportation of the Injured," "Radiation Fallout Detection and Monitoring," "Techniques for Survival—Water, Food, Clothing, Shelter Improvisations," "Mass Behavior Patterns in Disaster," "Legal Obligations and Moral Obligations in Disaster," and others.

Persons desiring to attend the conference should write to the AMA Council on National Security, 535 N. Dearborn Street, Chicago 10, for additional information and advance registration.

# Seminar Offered In Legal Medicine

Texas physicians are invited to participate in a unique summer instructional program of the Law-Science Academy of America, devoted to nine weeks of teaching in "Legal Medicine and Elements of Medicolegal Litigation." Slated for June 12 through August 11, the seminar is held at Law-Science Academy Hall, Crested Butte, Colo.

President of the Academy is Dr. Stephen R. Lewis, Jr., chief of the Division of Plastic and Maxillofacial Surgery, University of Texas Medical Branch, Galveston, with Dr. Hubert Winston Smith, chancellor of the Academy, as director and moderator. Dr. Smith, M.D., LL.B., is professor of law and legal medicine at the University of Texas, Austin.

The Law-Science Academy of America is a non-profit, charitable corporation, made up of more than 800 lawyers, physicians, judges, teachers in medical and law schools, and others who are interested in seeing scientific standards of medicine maintained in the evaluation and trial of personal injury cases. (Today these constitute 80 per cent of the trials occurring in Civil Courts of this country.)

The summer courses are arranged into one-week segments, each completely self contained, yet so constructed as to have an interlocking relationship with the preceding or following courses. Registration fees are used solely to defray expenses of the teaching effort, and scholarships are available to medical school teachers, to medical students, to teachers in law schools, and to law students.

Lecturers dated for the summer courses include Dr. L. M. N. Bach, associate professor of physiology, Tulane Medical School, New Orleans; Dr. John Blaschke, chief of internal medicine, McBride Orthopedic Clinic, Oklahoma City; Dr. Robert M. Moore, professor and chairman, Department of Surgery, University of Texas Medical Branch, Galveston; Dr. Milton S. Thompson, professor of forensic orthopedic surgery, Law-Science Institute, University of Texas, and recent chief of orthopedic surgery, Walter Reed Hospital, Washington, D. C.

Also William H. Tonn, Jr., Ph.D., consulting engineer and scientific analyst, traffic collisions, Houston; Dr. Ralph N. Baillif, professor of anatomy, Tulane Medical School, New Orleans; Dr. James Greenwood, clinical professor of neurological surgery, Baylor University College of Medicine, Houston; Dr. George Milles, professor of pathology, University of Illinois College of Medicine, Chicago; Alvin Doyle, Jr., consulting engineer and scientific analyst, traffic collisions, Baton Rouge, La.; Dr. Howard M. Burkett, associate professor of psychiatry, University of Texas Southwestern Medical School, Dallas.

Also Dr. William L. Waldrop, Division of Orthopedics and Fracture Surgery, University of Oklahoma Medical School, Oklahoma City; Dr. Ira J. Jackson, Section on Neurological Surgery, University of Texas Medical Branch, Galveston; Dr. John R. Derrick, head of the Section on Cardiovascular Surgery, University of Texas Medical Branch; Dr. McCarthy DeMere, division of plastic surgery, University of Tennessee School of Medicine, Memphis.

Also Dr. Donald Duncan, professor and chairman, Department of Anatomy, University of Texas Medical Branch; Dr. Robert H. Pudenz, specialist in neurological surgery, Pasadena, Calif.; Dr. Mary Ruth Jackson, assistant clinical professor, University of Texas Southwestern Medical School, Dallas; Dr. Ronald A. Welsh, associate professor of pathology, Louisiana State University Medical School, New Orleans.

Also Dr. Vincent P. Collins, professor and chairman, Department of Radiology, Baylor University School of Medicine, Houston; Dr. E. S. Gurdjian, professor of neurological surgery, Wayne Medical School, Detroit; Dr. W. F. Henly, Division of Cardiovascular and Thoracic Surgery, Baylor University College of Medicine, Houston; Dr. Herbert C. Modlin, senior psychiatrist, Menninger Clinic, Topeka; Dr. Philip O'B. Montgomery, associate professor, Department of Pathology, University of Texas Southwestern Medical School, Dallas.

Also Dr. Arthur Grollman, professor and chairman, Department of Experimental Medicine, University of Texas Southwestern Medical School, Dallas; Dr. Samuel B. Johnson, professor and chairman, Department of Ophthalmology, University of Mississippi Medical School, Jackson; Dr. Rudolph J. Muelling, Jr., professor and chief, forensic pathology, University of Kentucky Medical School, Lexington, Ky.; Dr. B. Clary Bates, specialist in surgery and urology, Austin.

Also Dr. James J. O'Donnell, specialist in orthopedic surgery, Colorado Springs, Colo.; Dr. Walter O. Klingman, professor of neurology and psychiatry, University of Texas Medical Branch; Dr. Robert A. Groff, professor and chairman, Department of Neurological Surgery, University of Pennsylvania, Philadelphia; Dr. William H. Ainsworth, Division of Orthopedic Surgery, University of Texas Medical Branch, Galveston; Dr. Hamilton Ford, professor of psychiatry, University of Texas Medical Branch; Dr. Joseph A. Jachimczyk, chief medical examiner and forensic pathologist, Harris County, Houston; and Dr. Russell T. Snip, ophthalomologist and surgeon, San Antonio.

Outstanding trial counsels to participate in teaching sessions on medicolegal trial technique will be announced later.

Further information and application forms are available from Dr. Hubert Winston Smith, Townes Hall, University of Texas Law School, 2500 Red River, Austin 5, Texas.

## Plans Progressing For Southwest District Meet

Nationally prominent medical authorities speaking on topics of immediate general interest, an expanded exhibit program, a Texas AGP seminar and District Heart Association session preceding the formal meeting—plus the traditional dance, golf, and boating—are all planned for the July 7-8 Southwest District Medical Meeting, in which the state's Southern and Gulf Coast medical districts are joining.

Speakers dated for the Corpus Christi meet include Dr. Manuel E. Lichtenstein, associate professor of surgery at Northwestern University Medical School and professor of surgery at the Cook County Graduate School of Medicine, who will discuss "Complications and Sequelae Following Cholecystectomy, Intestinal Obstruction, and Colostomy, Types and Indications."

Others on the program will be Dr. Newell W. Philpott, Montreal, Quebec, who will discuss "Trends and Treatment in Female Genital Cancer" and "Endometriosis"; Dr. William K. Wright, Houston, who will speak on "Nasal Fractures" and "Control of Epistaxis"; and Dr. Dan Jenkins, Houston, whose two papers will concern "Diseases of the Chest."

## Medical Writing Awards Open to Young M.D.'s

Now open is the 1961 Modern Medical Monographs Awards competition, which may be entered by graduate physicians less than 40 years of age.

Previously unpublished manuscripts in the field of internal medicine are eligible. Manuscripts, including illustrations (if any), should be submitted in duplicate by registered mail, postmarked no later than December 1, 1961, to Dr. Irving S. Wright, 450 East 69th Street, New York City 21. Manuscripts, including bibliography, must consist of not less than 130, or more than 200, double-spaced typewritten pages with one-inch margins; and no more than 30 illustrations, which might be pictorial charts, drawings, diagrams, or photographs. Fishbein's book, "Medical Writing" (third edition), should be followed in preparation of the manuscript.

First prize is $500. Authors of other top manuscripts which are found suitable will be offered a contract for publication of their work as a book in the series, *Modern Medical Monographs,* under standard royalty arrangements.

## *Panhandle District Elects Dr. McDaniel*

Dr. Macfield McDaniel, Pampa, became president of the Panhandle (Third) District Medical Society when that group held its April 15 meeting at the Herring Hotel in Amarillo.

Other officers elected for 1961-62 include Dr. A. W. Bronwell, Lubbock, president-elect; Dr. Dale Watkins, Wellington, first vice-president; Dr. J. Victor Ellis, Amarillo, second vice-president; and Dr. H. Fred Johnson, Amarillo, secretary.

The society voted to endorse Dr. Joe R. Donaldson, Pampa, as a candidate for the Texas Medical Association Board of Trustees.

Scientific program participants included Dr. Stanley R. Friesen, professor of surgery, University of Kansas Medical Center, Kansas City; Dr. C. Thorpe Ray, professor and chairman of the Department of Medicine, University of Missouri School of Medicine; Dr. Herbert Harris, professor and chairman, Department of Otolaryngology, Baylor University College of Medicine; Dr. Mary Ellen Haggard, associate professor, Department of Pediatrics, University of Texas Medical Branch; and Dr. Philip J. Krupp, assistant professor of clinical obstetrics and gynecology, Tulane University School of Medicine.

Special guests were Dr. May Owen, Fort Worth, and C. Lincoln Williston, TMA executive secretary, Austin.

The 1962 meeting of the group will be held in Pampa during September, 1962.

## Fourth District Surgeons Hold Tyler Sessions

Dr. John Paul North of Chicago, Director of the American College of Surgeons, and Dr. Conrad G. Collins, professor and chairman of the Department of Obstetrics-Gynecology, Tulane University School of Medicine, were featured speakers when the Fourth District of Texas Chapter, American College of Surgeons, held its ninth annual session May 13 in Tyler.

Texas physicians participating in the program were Dr. R. Harvey Bell of Palestine, president; Dr. A. J. Harrell, Dallas; Dr. John C. Turner, Jr., Tyler; Dr. Arthur Grayson, Dr. Philip Morrow, Dr. Donald R. Klein, Dr. William W. Hoffman, and Dr. J. M. Bardwil, all of Dallas; Dr. J. P. Graves, Marshall; Dr. Albert O. Loiselle, Dr. Marvin G. Shepard, Dr. G. Tom Shires, Dr. William F. Guerriero, and Dr. Z. H. Lieberman, all of Dallas.

The scientific program was followed by a chapter meeting, a reception, and dinner.

Dr. Harvey Renger accepts gavel as president of Texas Medical Association from Dr. May Owen.

# International Speakers, New Trustees Features of 1961 TMA Annual Session

With the second largest attendance in the history of Texas Medical Association Annual Sessions, the April, 1961, meeting in Galveston also recorded a number of "firsts."

Four international speakers representing England, Italy, and Canada were among the 29 guest speakers and 45 special speakers at the meeting, and two additional members were elected by the House of Delegates to the Board of Trustees, increasing the board membership from five to seven members.

Registered for the April 22-25 (Saturday-Tuesday) meeting were 3,323 individuals. Of this figure, 1,724 were members, 779 were guests, 215 were exhibitors, and 575 were members of the Woman's Auxiliary.

Features of the four-day meeting included specialty group meetings, refresher courses, scientific section programs, general meetings, technical and scientific exhibits, motion picture films, business, and social events. The latter included a golf tournament, a deep sea fishing party, a skeet shoot, fraternity and alumni parties, and the President's Party.

## Dr. Renger Becomes President

Dr. Harvey Renger, Hallettsville general practitioner and active civic worker, became the Association's 96th President during ceremonies at the President's Party on Tuesday night.

Since 1952, Dr. Renger has served as chairman of the Council on Medical Service and Insurance, to which he was appointed simultaneously as member and chairman, an honor seldom bestowed on an individual by a TMA President. During his tenure as chairman, three insurance programs were effected and the Physicians' Placement Service was expanded extensively.

A member of two Association committees, the

Dr. G. Astaldi of Tortona, Italy, right, one of four International guest speakers at Annual Session, talks with his sponsor, Dr. Raymond H. Rigdon, Galveston.

Sue Connally, Dallas Morning News reporter, interviews guest speakers from England, Dr. Kathleen Rains and Dr. John B. Fawcitt, husband and wife team.

Committee to Encourage and Assist Hospitals in Securing Accreditation and the Committee on Liaison with Blue Shield, Dr. Renger also is on the board of directors for Blue Cross-Blue Shield. He was for eight years a member of the Hospitals-Insurance-Physicians Joint Advisory Committee, and in 1951 he served as Councilor from District Eight.

Nationally, Dr. Renger is a member of the American Medical Association's Committee on Medical Service and Insurance and a fellow of the American College of Surgeons and of the International College of Surgeons.

In addition to his medical interests, he is active in numerous city and county organizations, the owner of a farm, and president of a grain and a cigar company in his hometown.

## Dr. Waldron Is President-Elect

Dr. George Waldron of Houston, the new President-Elect of the Association, served 10 years as a delegate to the Texas Medical Association; he was a member of the Council on Scientific Work for seven years and served on the Memorial Service Committee for 3 years. In addition, he has served the Association as a member and chairman of various reference committees.

Dr. Waldron belongs to 25 medical groups, some of which are the Southern Surgical Association, Texas Surgical Society, Southwestern Surgical Congress, American College of Chest Physicians, Association of American Physicians and Surgeons, American College of Surgeons, American Goiter Association, and International Society of Surgery. He is a member of Nu Sigma Nu medical fraternity.

Besides serving as president of the Harris County Medical Society in 1950, Dr. Waldron was president of the Houston Surgical Society in 1960 and of the Texas Surgical Society in 1953. He is now in his ninth year as Governor of the American College of Surgeons.

He was certified in 1940 by the American Board of Surgery.

Born July 21, 1904, in Santa Barbara, Calif., Dr. Waldron is the son of the late Robert George and LaVera (VanKirk) Waldron of Rochester, Minn.

He received his preliminary education in Rochester and attended Rochester Junior College there. In 1926, he was graduated with a bachelor of science degree from the University of Minnesota at Minneapolis; and in 1929, he was graduated with the medical de-

Dr. George Waldron of Houston, President-Elect, proofs story in Press Room.

Dr. Robert W. Kimbro, chairman of the Board of Trustees, briefs two new trustees, Dr. Charles P. Hardwicke of Austin and Dr. C. E. Willingham of Tyler. Dr. Hardwicke is immediate past speaker of House of Delegates.

gree from the University of Minnesota Medical School.

Following an internship at Garfield Memorial Hospital, Washington, D. C., from July, 1928 until June, 1929, he was a fellow in surgery at the Mayo Foundation for Medical Education and Research at Rochester, serving there from July, 1929, until October, 1934.

From 1934, until 1936, Dr. Waldron was the senior medical officer in charge of Ft. Peck Hospital, Ft. Peck, Mont., where he married Miss Rosalind Deakyne on April 24, 1935. She died April 17, 1949. The couple were parents of one son, George Van-Kirk Waldron, who is now stationed at Hamilton Air Force Base in California.

Dr. Waldron later married the former Miss Olivia Morgan of Houston and Los Angeles.

He began practicing surgery in Houston in January, 1937, became clinical professor of surgery at Baylor University College of Medicine in 1948, clinical professor of surgery at the University of Texas Postgraduate School in 1950, and chief of surgery at Hermann Hospital, Houston, in 1948, all of which are current positions.

Dr. Waldron has been author or co-author of 33 published medical papers.

## Other Officers Named

Other officers elected by the Association during Annual Session include Dr. R. Mayo Tenery of Waxahachie, Vice-President; Dr. James D. Murphy of Fort Worth, Speaker of the House of Delegates; and Dr. Charles Max Cole of Dallas, Vice-Speaker of the House of Delegates.

Four reelected Councilors include Dr. C. E. Oswalt, Jr., of Fort Stockton, First District; Dr. Stephen B. Tucker of Nacogdoches, Tenth District; Dr. R. H. Bell of Palestine, Eleventh District; and Dr. Travis Smith of Abilene, Thirteenth District.

New Councilors include Dr. S. Braswell Locker of Brownwood, Fourth District; Dr. James H. Sammons of Highlands, Ninth District; and Dr. B. E. Park of Dallas, Fourteenth District.

Delegates to the American Medical Association were all reelected: Dr. T. C. Terrell of Fort Worth, Dr. M. O. Rouse of Dallas, Dr. J. B. Copeland of San Antonio, and Dr. J. C. Terrell of Stephenville.

Three AMA alternate delegates were reelected, including Dr. Denton Kerr of Houston, Dr. George Turner of El Paso, and Dr. J. L. Cochran of San Antonio. Dr. R. D. Moreton of Fort Worth was elected to fill a vacancy created by the death of Dr. James Rainer of Odessa.

## House of Delegates Action

One of the most significant actions taken by the House of Delegates was the election of two new trustees, increasing board membership from five to seven. Dr. C. E. Willingham of Tyler and Dr. C. P. Hardwicke of Austin, former Speaker of the House of Delegates, are the newly chosen trustees.

Dr. J. B. Copeland of San Antonio was reelected as a trustee.

Other action taken by the House included approval of a resolution opposing the compulsory use of generic names in writing prescriptions. It also voted that this action be made known to the American Medical Association, the Texas and American Hos-

pital Associations, and the Pharmaceutical Manufacturer's Association.

The House voted to discontinue the Special Committee on Reorganization upon this committee's recommendation. Dr. Drue O. D. Ware of Fort Worth complimented the committee members and expressed the delegates' gratitude for its fine work.

Also discontinued were the Committee on Bracero Insurance and appointment of Advisor to the State Board of Education "until such time as Texas Medical Association is called upon for such service."

The House passed a resolution commending Mr. Walter R. McBee and Blue Cross-Blue Shield of Texas, and pledged its support to furthering programs and activities of Blue Cross-Blue Shield in the future.

A resolution from the Committee on Hospital Care of Rural Medically Indigent was approved. It asked that the Governor of Texas "appoint a Commission to study the problems of hospitalization of the indigent in Texas and make recommendations for a legislative act to provide adequate hospitalization for the medically indigent."

The subject of foreign interns and residents aroused a great deal of discussion in the House. In disapproving a resolution that had been introduced by McLennan County Medical Society, House members upheld recommendations of the Educational Council for Foreign Medical Graduates which have been designed to maintain high standards of medical care in this country.

Delegates approved a measure from the Council on Medical Education and Hospitals to encourage voluntary contributions to the American Medical Education Foundation. They upheld a recommendation that remuneration of residents and interns be at a level to allow them a decent standard of living and to help them avoid debt in providing for the basic necessities of life.

The House voted approval of a resolution regarding general practice residencies proposed by the Tarrant County Medical Society delegation. This resolution, to be introduced by the Texas delegation during the American Medical Association meeting next month, asks the AMA Council on Medical Education and Hospitals to formulate two-year progressive training programs acceptable to the American Academy of General Practice and to make "the necessary changes in 'The Essentials of Residency Training' to implement this resolution."

A resolution from Hill County Medical Society to allow interns and residents credit for attendance at orientation programs in fulfillment of the stipulation for regular membership was passed, and a change in the By-Laws to clarify this point was approved.

The recommendation of the President, Dr. May Owen, that the Special Committee on Medical Careers be made a standing committee was upheld by the House. Earlier, Dr. R. W. Kimbro, Chairman of the Board of Trustees, had offered the support of the Trustees in the implementation of this Committee's program.

Recognized by the House were the contributions in the field of medical education of a former chairman of the Board of Trustees—Dr. Merton M. Minter of San Antonio.

After careful study of an investment-retirement

Members of the credentials committee meet to verify qualifications of county medical society delegates seeking admission to Texas Medical Association's House of Delegates first session.

Dr. Arthur Zappe of Mineral Wells, president of the Texas Dental Association, is shown with Dr. E. Vincent Askey of Los Angeles, president of American Medical Association.

program by the Committee on Association Insurance Programs, the House of Delegates asked that the Committee explore the possibility of establishing a plan of this type independent of formal participation by the Texas Medical Association. The House recommends that after formulating full details of the program and securing approval of federal and state regulatory bodies, if necessary, the Committee present the proposal to the Board of Trustees and to the Council on Medical Service and Insurance for further consideration.

Dr. Edward Annis, Miami surgeon, delivers talk before members of the House of Delegates at Blue Cross-Blue Shield luncheon.

In approving portions of the report from the Council on Medical Jurisprudence relative to medical care, the House voted approval of the principle that financial aid should be contained within the state, insofar as practicable.

The House approved a resolution which recommended that health and medical care facilities available be surveyed by each county medical society in Texas. This resolution, introduced by Navarro County Medical Society, asks that the following data be obtained and forwarded to the Texas Medical Association for statewide tabulation: (1) population of the county; (2) number of active physicians in the county; (3) number of active nurses; (4) hospital beds available; (5) distance of hospital from sources of population; (6) type of funds available to pay for charity health services of medical facilities, including private sources, church sources, and county or other tax supported services; (7) persons 65 and

General Practitioner of the Year, Dr. Clark Campbell of Itasca, is object of a proud smile from his wife.

over who have prepaid voluntary insurance; (8) number of people receiving Social Security benefits, including those with and without voluntary prepaid insurance.

The Executive Secretary reported that the Speaker's Bureau of the central office staff fulfilled 127 engagements during the year and has expanded its facilities. The Reference Comittee on Reports of Officers and Committees, in approving this report, commended the central staff for the numerous hours devoted to this service.

Committee members congratulated the entire Association on the success of the Harriet Cunningham Memorial Graduate Fellowship in Medical Writing,

and reminded those in attendance at the House of Delegates meeting that memorial contributions to this fund are still in order.

The Board of Trustees reports that the value of the Dr. S. E. Thompson Fund has increased 67 per cent within a 3-year period. From an original value in January, 1958, of $509,000, this Fund has enlarged to its present value of $851,000. During this past year alone, 71 loans totaling $35,200 were made to students at the University of Texas Medical Branch, Galveston. The trustees predict that the Fund's enhanced value should enable an even larger number of loans to be made to students in the future.

The House of Delegates also commended the trustees for the excellent manner in which they have handled the Association's funds.

The House also recognized Dr. E. Vincent Askey of Los Angeles, President of the American Medical Association, and Dr. Edward R. Annis of Miami, Fla., for their contributions to the success of the Annual Session. Both were speakers.

## Tribute Paid Senior Members

Tribute was paid to two senior members of the Association: Dr. Britton Elbridge Pickett of Carrizo Springs and Dr. Clark Campbell of Itasca.

In addition, thirty doctors were elected to honorary membership in the Association.

Dr. Pickett, whom the House elected to emeritus membership by acclamation, stated that "medicine has made more progress in the past 60 years than in the previous 6,000 years."

He pointed out that he had been a part of medicine for that 60 year span, and predicted that the medical profession would progress at least as far during the next similar period if it is "unhampered and untrammeled."

"You, Gentlemen, will have a chance to make this so," he told the House of Delegates.

Dr. Pickett served as President of the Texas Medical Association in 1947, and was a member of the American Medical Association Council on Constitution and By-Laws from 1948-1960. Upon the occasion of his resignation as Chairman of the AMA Council, he was awarded an inscribed plaque with a Biblical quotation: "Behold how good and pleasant it is for brethren to dwell together in unity.—Psalms 133:1."

A physician for 41 years in Itasca, Dr. Clark Campbell, 71, originally practiced in Newport, after his graduation in 1913 from Texas Christian University. He was born October 28, 1889, at Huron, the oldest of eight children of Mr. and Mrs. R. C. Campbell. In 1916, he married Miss Anna McMahon of Dallas.

Dr. Campbell has served his community for 39 years as city health officer; he has been president of the Hill County Medical Society twice; he is a charter member and past president of the Itasca Rotary Club. For 37 years he has been president of the Hickey Fishing Club and for 11 years he has been a member of the Itasca School Board, serving as president four times.

Cited by his colleagues as "kindness personified," Dr. Campbell has been known to take time out in his busy office schedule to teach two little girls how to feed and care for a baby bird they had found.

On Dr. Campbell's birthday last October, the whole town of Itasca honored him with a special "Dr. Campbell Day," climaxed with a testimonial dinner.

Dr. N. C. Hightower of Temple works by the "sweat of his brow" to get scientific exhibits into shape.

# Auxiliary Convention Has "Treasure Isle" Theme

Carrying out the theme, "Treasure Isle," the Woman's Auxiliary to the Texas Medical Association held its annual convention, April 22-25, in Galveston.

Registration began at noon, on Saturday, April 22. Both Registration and the Hospitality Suite were open during the entire convention.

On Sunday morning, the Council Woman's Breakfast was held in the Tarpon Room of the Jack Tar Hotel. Mrs. Richard L. Hudson, Corpus Christi, First Vice President and the Officer in Charge of Membership and Organization, presided over this meeting.

The Executive Board of the Auxiliary met the same day for a luncheon meeting in the Charcoal Galley of the Jack Tar Hotel. Dr. H. O. Padgett, Chairman, Texas Medical Association Advisory Committee to the Woman's Auxiliary, brought greetings from the Association. He commended the Woman's Auxiliary for its splendid work during the past year. Auxiliary business and recommendations were presented by officers and chairmen.

A highlight of the meeting was Mrs. Ramsay H. Moore's report to the TMA House of Delegates on Saturday evening, April 22, at 8:00 p.m. She presented a $1,500 contribution to the Texas Medical Association Memorial Library. Dr. R. W. Kimbro, Chairman of the TMA Board of Trustees, accepted the contribution. The Auxiliary raised the money by the sale of the cookbook assembled and edited by Mrs. Benjamin F. Simms, Austin. Mrs. Simms was introduced by Mrs. Moore. In accepting the check, Dr. Kimbro pointed out that it will increase the ability of the Library to furnish association members with the materials they need.

Mrs. Moore also reported that the State Auxiliary had given more than $17,400 to the American Medical Education Foundation. Also, the Woman's Auxiliary had assisted with or sponsored science fairs this year; 380 schools were assisted with 9,156 exhibits. She reported that 175 new Future Nurses Clubs have been organized this year, that 22 clubs were interested in medical careers clubs, and that one Future Medical Club and one Future Doctors' Club had been organized. Mrs. Moore reported that during the past year, emphasis had been placed on fellowship, public relations, and community service, to which over 900,000 hours had been given.

Memorial services of the Texas Medical Association and Woman's Auxiliary were held on Sunday afternoon. Dr. G. W. N. Eggers of Galveston and Mrs. Van D. Goodall of Clifton gave memorial addresses.

Mrs. John D. Gleckler, Denison, was chairman for the Auxiliary Past Presidents' Dinner on Sunday evening at the Buccaneer Club. Entertainment was provided, and portrait sketches were presented to each Past President and guest attending.

The First Business Session was called to order Monday morning in the Oak Room of the Jack Tar Hotel. The Invocation was given by Mrs. Edward P. Waller of San Antonio. The Address of Welcome was given by Mrs. William A. Wilson, convention chairman of Galveston, and the Response by Mrs. Tom M. Oliver of Waco. Mrs. Mark H. Latimer of Houston led the group in reciting the Credo and Pledge. Reports of County Presidents and Council Women were presented.

A luncheon honoring county presidents was held in the Charcoal Galley on Monday. Mrs. O. W. Robinson, Paris, introduced Mrs. Kalford W. Howard, Portsmouth, Va., President of the Woman's Auxiliary to the Southern Medical Association, who brought greetings from that organization. Mrs. Garland G. Zedler of Austin introduced Mrs. William Mackersie, Detroit, Mich., who brought greetings from the Woman's Auxiliary to the American Medical Associ-

Mrs. Ramsay H. Moore, Dallas, and Mrs. Garland G. Zedler, Austin, outgoing and incoming Presidents of the Auxiliary, respectively.

ation. Dr. May Owen, TMA President, presented an address to the group commending the county presidents and state officers for their work during the year, and pledged the continuing support of the Texas Medical Association. Mrs. Ramsay H. Moore, President of the Woman's Auxiliary, presented Dr. Owen a gift of a gold charm from the Woman's Auxiliary in tribute to her high honor as the first woman president of the Texas Medical Association and also as an Honorary Life Member of the Auxiliary. Also, from the Auxiliary, in appreciation of service to the 5,800 members, she presented two silver trays to Dr. Owen for TMA Headquarters Building to be used in serving at the Texas Medical Association meetings held there.

The Second Business Session of the Woman's Auxiliary continued in the Charcoal Galley following the luncheon. Mrs. Madison J. Lee, Tyler, Chairman of the Historical Committee, presented the awards to county auxiliaries. The silver membership cup was won by the Grayson County Auxiliary.

A Treasure Hour was held Monday afternoon in the Quarterdeck Club. It honored Mrs. Ramsay H. Moore, President, and the 1960-1961 State Officers.

Tuesday's general business meeting was a continuance of reports. Reports of State Officers were heard, and it was evident that a great number of accomplishments in many areas of auxiliary work had been realized during this year.

Among actions taken by the convention were the following: All Past State Presidents of the Woman's Auxiliary will automatically become Honorary Life Presidents; $1,000 was given to the American Medical Education Foundation as a memorial to auxiliary members deceased during the past year; $1,500 was presented to the TMA Memorial Library from the sale of the cookbook; additional funds from the Library Fund amounting to $563.70 were approved for presentation to the TMA Library to purchase new films.

Mrs. Thomas J. Vanzant, Houston, committee member, in the absence of Mrs. Haskell D. Hatfield, El Paso, Chairman of the Nominating Committee, presented the following slate of officers for 1961-1962, who were elected unanimously: President, Mrs. Garland G. Zedler, Austin; President-Elect, Mrs. R. C. L. Robertson, Houston; First Vice President, Mrs. Richard L. Hudson, Corpus Christi; Northern Regional Vice President, Mrs. J. Robert Cochran, Fort Worth; Eastern Regional Vice President, Mrs. Roger Q. Harmon, Marshall; Southern Regional Vice President, Mrs. James C. Price, Gonzales.

Also Western Regional Vice President, Mrs. Bruce Hay, Pecos; Recording Secretary, Mrs. P. D. Terrell, McAllen; Corresponding Secretary, Mrs. Sidney W. Bohls, Austin; Treasurer, Mrs. Russell L. Deter, El Paso; Publicity Secretary, Mrs. Van D. Goodall, Clifton; Parliamentarian, Mrs. H. S. Renshaw, Fort Worth.

The Installation and Style Show luncheon was held Tuesday noon at the Grecian Room of the Galvez Hotel. Mrs. George Turner, El Paso, installed the new officers. She paid tribute to Mrs. Ramsay H. Moore, outgoing president of the Woman's Auxiliary. Mrs. Moore presented the gavel and president's pin to Mrs. Garland G. Zedler of Austin. Mrs. H. S. Renshaw of Fort Worth presented the Past President's Pin to Mrs. Moore. Mrs. Moore received a gift of a silver bowl from her Dallas Auxiliary. The 1960-1961 Session was then adjourned.

### Post-Convention Meeting

The Post-Convention Board meeting was held Tuesday afternoon, with Mrs. Zedler presiding. Dr. Harvey Renger, Hallettsville, President of the Texas Medical Association, asked for the cooperation of the Auxiliary members in opposing socialistic measures in this country. He stressed the seriousness of the present situation in regard to socialization of medicine, and urged that everyone interested in medicine present a unified front against socialistic trends. State Officers, Committee Chairmen, Council Women, and county presidents were introduced.

"Information and Service" will be the theme for the 1961-1962 Convention year.

Among special guests of the convention were Mesdames William Mackersie, Detroit, Mich., President of the Woman's Auxiliary to the American Medical Association; Kalford W. Howard, Portsmouth, Va., President of the Woman's Auxiliary to the Southern Medical Association; Philip R. Overton and C. Lincoln Williston of Austin; William Proudfit, Cleveland, Ohio; T. C. Panos, Little Rock, Ark.; Owen H. Wangensteen, Minneapolis; Paul R. Dumke, Detroit, Mich.; George E. Shambaugh, Jr., Hinsdale, Ill.; Robert J. Coffey, Washington, D. C.; E. Vincent Askey, Los Angeles; John W. Henderson, Rochester, Minn.; Laurence L. Robbins, Boston; and John Fawcitt, Manchester, England. Also present were Mrs. Martha Owens, Miss Ruth Trahan, and Miss Pauline Duffield, members of the TMA Staff in Austin, and Mrs. Nola Acton, Executive Secretary to the Auxiliary.

# Association Council Sparks Move To Find Babies with Phenylketonuria

At the Texas Medical Association annual session just concluded in Galveston, the Council on Medical Jurisprudence agreed to launch an educational program for physicians to encourage the detection of phenylketonuria (PKU) in newborn infants. Early recognition and prompt treatment can prevent mental retardation.

The Council voted not to support H. B. 1042 for this purpose, introduced in the current Texas Legislative session by Maco Stewart of Galveston. Its members agreed that an educational approach to the problem of detection of the disease should be more effective than legislative efforts.

Phenylketonuria, which results from a genetic defect, can be detected a few weeks after birth by use of paper strips (Phenistix), by sprinkling a wet diaper with 10 per cent ferric chloride (Schieffelin test kit), or by use of dinitrophenyl-hydrazine test solution. For large scale screening, the Phenistix or dried urine-impregnated filter paper can be used and paper chromatography applied. For detection of the condition in neonates, especially for siblings of children known to have phenylketonuria, direct blood tests with paper chromatography or the enzymatic test of LaDu and Michael are recommended.

Treatment consists of administration of a diet low in phenylalanine, since the patient lacks the enzyme which normally permits utilization of this amino acid. Dietary preparations, including Merck and Mead Johnson products, are available as milk substitutes. The earlier treatment is begun, the more effective the results; the special diet should be given by the time the infant is one month old to prevent brain damage. Untreated, such children are usually severely retarded by the time they are 7 years old.

Educational programs on phenylketonuria have been highly successful in certain areas. In California, Missouri, Washington, New York City, and several other vicinities, all babies brought to maternal and child health clinics are screened for phenylketonuria with the simple "diaper test."

In Akron, Ohio, a private hospital, in cooperation with the local association for the mentally retarded, is experimenting with do-it-yourself kits for mothers of newborn babies to take home with them. They are informed that the baby must be 3 weeks old for the test to be effective, since it takes that long for sufficient phenylpyruvic acid to appear in the urine. A similar program in Cincinnati hospitals was responsible for finding one baby with phenylketonuria and another with diabetes. In Kansas and several other states, children in institutions who are mentally retarded are tested. If the condition is found in them, the other children in their families are tested, since the chance of a second sibling being similarly affected is one in four (25 per cent).

Testing has indicated that 200 to 400 babies with phenylketonuria are born each year and that the disease is responsible for at least 1 per cent of the 200,000 mentally retarded now in institutions.

More detailed information and reference materials on phenylketonuria are available from the medical literature* and the U. S. Children's Bureau.

*The following articles are recommended:*

*1. Baird, H. W., III: Reliable Paper-Strip Method for Detection of Phenylketonuria, J. Pediat. 52:715 (June) 1958.*

*2. Berry, H. K., et al.: Simple Method for Detection of Phenylketonuria, J.A.M.A. 167:2189 (Aug. 30) 1958.*

*3. Horner, F. A., and Streamer, C. W.: Phenylketonuria Treated from Earliest Infancy, J. Dis. Child. 97:345 (March) 1959.*

## Lackland, Mexico Try Two-Nation Therapy Venture

The Lackland Air Force Base Hospital, San Antonio, and the Mexican Rehabilitation Center at Tialpan, Mexico, have joined in a "hands across the border" program of technical cooperation.

Air Force rehabilitation specialists, working through the International Cooperation Administration Office at the U. S. Embassy in Mexico City, will provide training and instruction for the Mexican personnel; in return, the American group will benefit from ideas originating at Tialpan.

Initial areas covered in the program are physical and occupational therapy, but it is anticipated that other specialties will be included in the future. Proposal for the two-nation venture came from Maj. Gen. O. K. Neiss, Air Force Surgeon General. Lt. Col. Mary M. Laughlin and Major Elsie Deming, Lackland chiefs of physical and occupational therapy services, devised the program, which is directed by Captain Floyd H. Holmgrain.

## Medical Writing Awards Announced; Miss Clapp Wins in First Category

Recipient of the Anson Jones Award for excellence in reporting health information during 1960 in the metropolitan daily newspaper category is Miss Marjorie Clapp, medical writer for the *San Antonio Light.*

Miss Clapp previously has won second and third place honors. She will receive an award certificate and $250, and her newspaper will receive a mounted bronze plaque for providing her the opportunity to cover news of medical interest.

In the second Anson Jones category for daily newspapers in cities of less than 250,000 population, the winner was Mrs. Mary Tom Rasco of the *Amarillo Globe-News.* Last year, Mrs. Rasco was third place winner.

Jack Stengler, editor of *The Alice News,* received the top award in the third category, for weekly newspapers in Texas. This was his first entry.

In the fourth category, for magazines and trade journals in Texas, the award went to Mrs. Lois Hill, editor of *Intercom,* monthly publication of St. Luke's Episcopal and Texas Children's Hospitals in Houston.

Winners in the second, third, and fourth categories will receive an award, certificate and check for $100, and their publications will receive a bronze plaque of appreciation.

This is the first year in which the contest has been divided into categories for newspapers, and it is the first year in which magazines and trade journals have been eligible to enter.

Judges for the awards were Norris G. Davis, Ph.D., associate professor of journalism at the University of Texas School of Journalism; Blair Justice, medical and science editor, *Fort Worth Star-Telegram* and first place winner twice of the Anson Jones Award; Miss Ruth Trahan, managing editor of the TEXAS STATE JOURNAL OF MEDICINE; and members of the Texas Medical Association's Council on Public Relations and Public Service.

---

### How It Was 100 Years Ago

Back in Civil War days soldiers tore the cartridges for their muzzle-loaders with their teeth. When their front teeth gave out, they were discharged from the service. Physical qualifications until World War II required each man to have adequate opposing teeth —apparently a holdover from Civil War requirements.

—Medicine at Work,
March, 1961.

## *UT Medical Branch Gains Former Czech Gynecologist*

Dr. Alois Vasicka, 43, has been appointed professor in the Obstetrics and Gynecology Department of the University of Texas Medical Branch, Galveston.

A native of Czechoslovakia, Dr. Vasicka has distinguished himself in research in his specialty during his 10 years in America. He is best known as principal investigator of new techniques for exact measurement of the effects of anesthesia and pain-killing drugs on uterine contractions during labor.

A diplomate of the American Board of Obstetrics and Gynecology, Dr. Vasicka comes to Galveston from Cleveland, Ohio, where he was assistant professor at Western Reserve University School of Medicine. He held appointments in his specialty at the Cleveland Metropolitan General and University hospitals.

One of Dr. Vasicka's medical studies uncovered new knowledge of the causes of maldevelopment of the child and prenatal arrest of brain defects. Another developed a method of predetermining the sex of the unborn child by microscopic observations of sex chromatins extracted from the mother's amniotic fluid.

At the Medical Branch, Dr. Vasicka will work with other faculty members on a variety of research activities. One of his most important current research projects is into effects of the mother's central nervous system on the action of the uterus during labor.

During World War II, Dr. Vasicka was a medical student at Brno, formerly capital of the Moravian sector of Czechoslovakia, and received his medical degree from Masaryk University there. When Communists took control of his homeland, he and his sister risked death in escaping across the two-mile strip of "forbidden" land which forms the iron curtain between Czechoslovakia and Austria.

Prior to his five years at Western Reserve University, he was a research fellow at Harvard Medical School and a resident at a number of Eastern hospitals.

Mrs. Vasicka, who will join her husband in Texas this summer, is a practicing obstetrician and gynecologist in Cleveland and is also on the faculty at Western Reserve University.

Dr. Haden McKay, Jr., of Humble, and friend. (Seen during TMA Annual Session in Galveston.)

# Personals

*Dr. Raymond L. Gregory,* professor of medicine since 1942 at the University of Texas Medical Branch, Galveston, has been appointed chairman of the Department of Internal Medicine at that institution, succeeding *Dr. James V. Warren. Dr. Gregory* is "being followed"—one son, *Dr. Charles Gregory,* is now a resident in medicine at the University of Minnesota, while another, *Fred Gregory,* will receive his medical degree in June from the College of Physicians and Surgeons of Columbia University.

*Dr. C. A. Peabody* and *Dr. V. P. Collins,* Houston, are co-authors of an article, "Penetrating Wounds of the Chest," in a recent issue of the *Journal of the American Medical Association.*

*Dr. and Mrs. Arthur Gleckler,* Sherman; *Dr. and Mrs. Willis G. Youens, Jr.,* Weimar; and *Dr. and Mrs. Harold M. Northington,* Wharton, were among 79 University of Texas exes who formed a two-week plane tour to Europe April 14-30. The "flying Longhorns" were to be welcomed by Texas Exes in London and Paris.

*Dr. William J. Campbell,* Amarillo ophthalmologist, has been elected president of the Amarillo School Board. He is also a member of the Amarillo College Board of Regents.

*Dr. Phillip Day,* San Antonio orthopedist, was the physician-member of a panel of experts which recently made talks in Spanish at the United Cerebral Palsy Treatment Center in San Antonio. The program was aimed at helping Spanish-speaking parents meet the needs of their children with the disease.

*Dr. S. H. Richardson,* Cameron, has been awarded that town's McCullin Civic Award. The presentation was made at a Cameron Chamber of Commerce banquet attended by 300 persons. Dr. Richardson is outgoing chamber president, Milam County health officer, and a member of the school board, and is active in church and community affairs.

*Dr. Nellins C. Smith,* Hillsboro, suffered a broken leg in a March horseback-riding accident in that city.

*Dr. Joe D. Nichols* of Atlanta, president of Natural Food Associates, a non-profit educational organization, addressed a public meeting in Nacogdoches recently. Owner of the 1,000 acre organic farm, Jonica Farms, he travels extensively across the nation lecturing on conservation of soil, water, and human health.

*Dr. E. F. Etter,* Sherman, has been elected to the board of directors of the Grayson County State Bank, of which he is a charter stockholder.

The Bexar County Academy of General Practice has adopted a resolution lauding *Dr. Merton M. Minter,* San Antonio, who recently retired as member and chairman of the University of Texas Board of Regents.

*Dr. C. P. Hawkins,* president of the Tarrant County Medical Society, was honored on Doctors' Day by the Woman's Auxiliary to the Southern Medical Association.

*Dr. J. Arnold Bargen, Temple,* has been reelected to membership on the Council on Scientific Assembly, American Medical Association. The only Texan currently serving on the council, Dr. Bargen is beginning his fourth year.

*Dr. Maxwell Lockie* of Buffalo, N. Y., an authority in arthritis, was a recent visitor to Houston, where he has many friends.

Four Baytown physicians, *Dr. L. A. Hankins, Dr. C. R. Waters, Dr. Clifford McCasland,* and *Dr. William E. Marshall,* were singled out for special tribute at a Doctors' Day Dinner by the Woman's Auxiliary to the East Harris Branch of the Harris County Medical Society. Among them, they have contributed almost 200 years of medical service to their community.

*Dr. Edward B. Singleton,* Houston, has been elected Surgeon General of the Texas Exes Association of the University of Texas.

*Dr. John McGivney,* Galveston, was among panelists discussing "Management of Ulcerative Colitis" during the May 14-18 International College of Surgeons annual session held in Chicago.

*Herbert B. Rice,* 68, businessman and stockbreeder, died in Marlin on March 24. He was the son of the late *Dr. S. P. Rice,* former president of the Texas Medical Association.

*Colonel Charles De Baren,* retiring medical group commander at Laredo Air Force Base, was recently presented a plaque in appreciation of his work at the base and with the Webb-Zapata-Jim Hogg Counties Medical Society by the latter group. The presentation was made at a meeting of the medical society and its auxiliary in Nuevo Laredo, Mexico.

The Corpus Christi Surgical Society's 1961 officers include *Dr. H. J. Eberle,* president; *Dr. R. R. Woods,* vice-president; *Dr. M. C. Kendrick,* secretary; and *Dr. G. B. Barnes,* treasurer.

*Dr. Raleigh R. White,* Temple, is vice-president of Certified Investment Company, Inc., a locally organized corporation, which has purchased the Hawn Hotel in Temple.

*Dr. Terrell Speed,* Temple, was reelected to the board of the Temple Independent School District in an April 4 election.

*Dr. and Mrs. Thomas O. Eller,* Plano, are the parents of a new son.

*Dr. Walter G. Crowe,* native of Pennsylvania and graduate of the University of Tennessee College of Medicine, has joined the staff of King's Daughters Clinic in Temple.

*Dr. Olin B. Gober,* president of Scott and White Clinic, has been elected to the board of directors of the Blue Shield Plan.

*Dr. John M. Knox,* associate professor in the Department of Dermatology, Baylor University College of Medicine, Houston, will discuss "Etiological Factors and Premature Aging" during a symposium on the "Problem of the Aging Skin" sponsored by the American Medical Association Committee on Cosmetics on June 28, during the New York AMA annual meeting.

*Dr. Clifton F. Douglass, Jr.,* has been appointed full time radiologist for the Bexar County Hospital District. He will serve as assistant to Dr. Billy D. King, chief radiologist at Robert B. Green Hospital, San Antonio.

*Dr. S. E. Shannon,* Karnes City health officer and long-time member of the Karnes City Board of Education, retired from active practice as a physician and surgeon on April 2. The story made front-page news in the *Karnes City Citation.*

*Dr. John H. Moyer,* formerly of Texas and now chairman of the Department of Medicine, Hahnemann Medical College, Philadelphia, presented three papers during the Second Hahnemann Symposium on Hypertension May 4-7.

*Dr. Michael E. DeBakey,* Houston, will be the Texas member of a panel discussing "Renal and Adrenal Hypertension" during the American Medical Association annual session in New York June 25-30.

*Dr. Valliant C. Baird,* Houston physician and chairman of the Texas Medical Association's Council on Industrial Health, has been appointed to the newly-created position of medical director in the headquarters organization of Humble Oil and Refining Company.

Among Texas' bumper crop of United States Senate candidates this spring was *Dr. Theodore Bisland,* Dallas ophthalmologist, who is a graduate of both Harvard Medical School and Southern Methodist University School of Law.

*Dr. A. J. Gill,* dean of the University of Texas Southwestern Medical School, was the subject of a recent "Headliner Portrait" in the *Dallas Morning News.* Said Dr. Gill, who was named Atticus for Rome's famous Titus Pomponius Atticus: "My friends call me Jim . . ."

*Dr. G. V. Brindley, Sr., Dr. T. F. Bunkley, Dr. J. S. McCelvey,* and *Dr. A. C. Broders, Sr.,* all of Temple, have been elected to honorary membership by the Bell County Medical Society.

*Dr. Martha Madsen,* staff pathologist at Midland Memorial Hospital and director of the Midland Diagnostic Cancer Clinic, was among candidates who filed in March to run for the Midland Independent School District's Board of Education.

*Dr. Pat McMurrey,* Baytown physician, was one of five alumni of Lee College recently cited by that institution as an "outstanding graduate." Other honorees included two professional engineers, a physical chemist, and a civic leader.

## Postgraduate Courses

*Physical Medicine and Rehabilitation for the Clinician,* Denver, June 1-3. Further information is available from the sponsoring Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20.

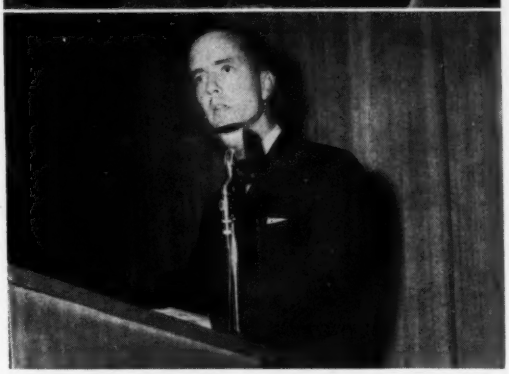
*Obstetrics and Gynecology,* Denver, June 19-21. Further information is available from the sponsoring Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20.

*External Ophthalmology,* Estes Park, July 10-13. The University of Colorado School of Medicine sponsors this postgraduate course, together with the Colorado Ophthalmological Society. Guest speakers will include Dr. Raynold N. Berke, Columbia University College of Physicians and Surgeons, New York City; Dr. Frederick C. Blodi, State University of Iowa College of Medicine; Dr. Ramon Castroviejo, New York University College of Medicine; and Dr. Frank W. Newell, University of Chicago School of Medicine, in addition to five faculty members from the host university. Registration and tuition fee is $60. Morning sessions allow for family vacationing in the afternoon. Information is available from the Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver 20, Colo.

*Cancer,* Denver, July 12-13.—The 15th annual Rocky Mountain Cancer Conference will be held at the Brown Palace West. Co-sponsored by the Colorado Division, American Cancer Society, and the Colorado State Medical Society, the meeting will have as participants both the president of the American Medical Association and the American Cancer Society. Application has been made for A.A.G.P. accreditation. Scientific program speakers will include Drs. Vincent P. Collins and John A. Wall, Houston; Dr. Ulrich R. Bryner, Salt Lake City; Dr. William Dock, Brooklyn; Dr. Manuel E. Lichtenstein, Chicago; and Dr. John R. McDonald, Detroit. Further information is available from the Conference office, 835 Republic Bldg., Denver 2, Colo.

### Texas Students Named by SAMA

Dennis E. Welch of Houston, student at the University of Texas Medical Branch at Galveston, recently was elected president of the Student American Medical Association, meeting in Chicago. Named vice president was Donald R. Payne of Wichita Falls, student at the University of Texas Southwestern Medical School at Dallas.



**Top.** Association's Executive Secretary, C. Lincoln Williston, speaks to members of Baylor senior class.
**Below.** William Mason, President of Baylor senior class, addresses group.

## Baylor Observes

For the eighth consecutive year, the Texas Medical Association presented a Medical Students' Day program at Baylor University College of Medicine in Houston.

The program, given before the 87-member senior class by members and staff of the Association, was planned to introduce the students to the practical aspects of the practice of medicine. Topics this year included medical licensure, public relations and socio-economic considerations, services of medical societies, medical ethics and etiquette, financing of a practice, and legal aspects of medicine.

At the evening session, more than 200 senior medical students, their wives, and other guests from the Harris County Medical Society and Baylor University College of Medicine enjoyed a dinner and an entertaining speech by Charles W. Jarvis, D.D.S., of San

**Left.** Charles W. Jarvis, D.D.S., of San Marcos, makes a humorous point during his talk on doctor-patient relationships.

**Right.** Dr. Stanley Olson, dean of Baylor University College of Medicine, accepts check for $10,906 on behalf of American Medical Education Foundation from Dr. D. J. Sibley of Fort Stockton.

# Medical Students' Day

Marcos. Dr. Jarvis' talk was entitled "Smile Awhile—The Human Factor in Doctor-Patient Relationships."

During a ceremony of the evening program, Dr. D. J. Sibley, Fort Stockton, a member of the Association's Committee for the American Medical Education Foundation, gave the medical school a check for $10,906, representing AMEF contributions from physicians. Dr. Stanley Olson, Dean of the Baylor Medical institution, accepted the check from Dr. Sibley.

In addition to its AMEF grant, Baylor University College of Medicine last year received $8,525 in direct gifts from its alumni. In the past five years, AMEF has made grants to Baylor totaling $56,350.25.

The Medical Students' Day program was presented with the cooperation of the Harris County Medical Society. Mead Johnson Laboratories co-hosted the dinner.

## "Murder" Talk Heard By Medical, Legal Groups

"Medical Investigation of Murders and Unexplained Deaths" was the subject of a talk heard recently by the Cameron-Willacy Counties Medical Society and the Cameron County Bar Association, which met jointly in Harlingen.

Dr. Philip O'B. Montgomery, associate professor of pathology at Southwestern Medical School, Dallas, was the guest speaker before the group of more than 100 attending lawyers and physicians.

Sharing presiding honors were Dr. David Flory, Harlingen, president of the medical society, and co-chairman Orrin W. Johnson of the local bar group. The meeting was covered by Harlingen radio, TV, and newspapers.

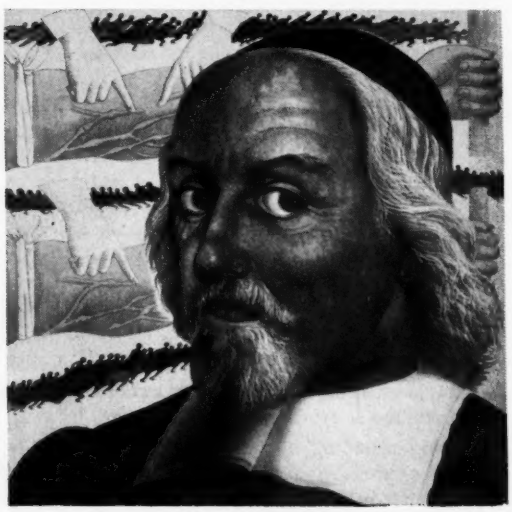
MEMORIAL LIBRARY

# William Harvey's Tomb: Is "De Motu Cordis" There?

Among the "anni mirables" of medical history one stands in bold relief as the greatest of the century, and probably the greatest in our medical past. That year is 1628 for, at that time, Harvey's "Anatomical Study on the Motion of the Heart and Blood in Animals," or "De Motu Cordis," as it is now called, was published. As has been said, "We all know that the triumph for a historian of science is to prove that nobody ever discovered anything." This does not hold for Harvey, for despite attempts to discredit him, he remains the true discoverer of the circulation of the blood.

"De Motu Cordis" is the basis for the physiology of the circulation as it is known today. This little book justly has been described as the "greatest piece of deductive reasoning the world has ever known." Sir Thomas Browne of "Religio Medici" fame, with his love of paradox, declared that he preferred the discovery of circulation of the blood to the discovery of America!

Harvey's book always is included in any collection of "Great Books of Western Literature" or with any "Nine Foot Shelf of Great Books of World Literature." Even with its grammatical defects the booklet is a masterpiece of clear thinking. It is even more admired because in the light of present knowledge, it is absolutely accurate. Harvey could not see the capillaries but he said that they had to be there. They were later seen by Malphigi.



WILLIAM HARVEY

—Copyright, 1954, by *The Heart Bulletin*, Houston, Texas. Reprinted by permission.

It has been of some concern to the author that the St. Andrew's Parish Church in Hempstead, where Harvey's body lies buried, has been collapsing for the past century. The bell tower fell in 1882 and the church otherwise is in a poor state of repair. Why Harvey is buried in this church is another story; Oliver Cromwell was in power in 1657 when Harvey died, and Harvey had been physician and personal friend to Charles I, which made him "personna non grata" in Westminster Abbey at the time. Harvey also had specified in his will that he wanted to be in the family vault in the Chapel at Hempstead.

The author considers it poetic justice that although Harvey's body remains uncared for, the knowledge in his booklet is increasingly loved and admired. Although not rare (there are 54 copies, according to Sir Geoffrey Keynes' census), "De Motu Cordis" is exceedingly difficult to procure at present. Most great medical libraries consider their copies the greatest book in the building. Many of the existing copies are being "thumbed to death" by avid admirers. The author does not know of a copy of "De Motu Cordis" that has changed hands in the past 20 years. Needless to say, the price will undoubtedly be $20,000 or more if a copy ever can be put on the open market.

In conversations with friends, the writer has often remarked what a shame it was that someone did not put a copy of "De Motu Cordis" in the vault with Harvey at the time of his death, for in 1657 the booklet was worth only a few shillings. The sale of the booklet now would provide funds to rebuild the bell tower and repair the church, leaving money to spare.

Recently, Mr. Arthur Dickson-Wright of St. Mary's Hospital in London visited Texas on his way home from a meeting of the British Medical Association in New Zealand. In discussing the value of the book and the disrepair of the church at Hempstead, Mr

Dickson-Wright said, "There is a copy of 'De Motu Cordis' in the tomb with Harvey." After returning to London, the surgeon sent the author a copy of a booklet, "List of Historical Objects and Memorials in Hempstead Church, Essex." Surely enough, the first item reads: "(1) Tomb of Harvey containing lead shell (containing body), parchment and copy of 'De Motu Cordis,' 1628."

How did the copy get into the tomb and who put it there? Mr. Dickson-Wright thinks that the book was put into the tomb on St. Luke's day, 1883, by the Royal College of Physicians when the body, "Lapt in lead," was removed from a vault and placed in a marble sarcophagus in the Hempstead Church. This is certainly possible, but the author doubts that it can be proved. Harvey's body must be in a poor state, since an observer in 1883 remarked that a frog jumped from a crack in the lead shell when a flashlight was thrown upon it. In any event, it is hoped that the valuable book is in better condition than Harvey.

What will happen when it becomes more generally known that this book is in the tomb? Probably it will be removed. Let us hope the money will be used to rebuild the church.

—W. M. CRAWFORD, M.D., Fort Worth.

## Gifts to the Library

Dr. George E. Clark, Austin, 234 journals.
Dr. Morris Davidson, Austin, 16 journals, 2 pamphlets.
Dr. William L. DeGinder, Austin, 59 journals, 3 books.
Dr. Enid Gilbert, Austin, 63 journals.
Dr. Lawrence E. Hamilton, Rogers, 14 books, 103 journals.
Dr. Alford R. Hazzard, Austin, 673 journals.
Dr. Henry L. Hilgartner, Austin, 14 journals, 7 pamphlets.
Dr. A. M. Horne, Midland, 2 journals.
Dr. Sam N. Key, Jr., Austin, 32 journals.
Dr. Heinrich Lamm, Harlingen, 10 reprints.
Drs. Cary and Georgia Legett, Austin, 53 journals, 51 pamphlets, 3 reprints.
Mrs. Harry J. Leon, Austin, 6 journals.
Dr. Robert W. Loveless, Bastrop, 8 books.
Dr. Claud A. Martin, Austin, 223 journals.
Mr. Philip R. Overton, Austin, 2 journals.
Purviance Clinic, Pampa, 52 books.
Mr. L. C. Scheh, Houston, 6 records.
Dr. Eugene P. Schoch, Austin, 20 journals, 1 book.
Dr. Oliver W. Suehs, Austin, 97 journals.

## New Books Received

Academy of Sciences, USSR: *Works of the Institute of Higher Nervous Activity: Pathophysiological series,* vol. 1, Moscow, Academy of Sciences, USSR, 1955. (Israel Program for Scientific Translations, 1960.)

Academy of Sciences, USSR: *Institute of Experimental Pathology and Therapy: Problems of Infectious Pathology in Experiments on Monkeys,* Sukhumi, Institute of Experimental Pathology and Therapy, 1958. (Russian Scientific Translation Program, 1961.)

Anan'yev, M. G., Ed.: *New Soviet Surgical Apparatus and Instruments and Their Application,* New York, Pergamon Press, 1961.

Armstrong, H. G.: *Aero-space Medicine,* Baltimore, Williams & Wilkins, 1961.

Birne, H.: *Wait for the New Grass,* New York, St. Martins Press, 1961.

*Britannica Book of the Year, 1961,* Chicago, Encyclopaedia Britannica, 1961.

Cherry, W. B.: *Fluorescent Antibody Techniques in the Diagnosis of Communicable Disease,* Washington, Public Health Service, 1960.

*Ciba Clinical Symposia,* vol. 12, Summit, N. J., Author, 1960.

Dubos, R.: *Mirage of Health,* Garden City, Anchor Books, 1961.

Goldman, R. P.: *Lose Weight and Live . . .,* New York, Doubleday, 1961.

Gordienko, A. N., Ed.: *Control of Immunogenesis by the Nervous System,* Rostov-on Don, State Medical Institute, 1958. (Israel Program for Scientific Translations, 1960.)

Hollinshead, B. S., Dir.: *The Survey of Dentistry,* Washington, American Council on Education, 1961.

Kavetskii, R. E., Ed.: *The Neoplastic Process and the Nervous System,* Kiev, The State Medical Publishing House, 1958. (Israel Program for Scientific Translations, 1960.)

Keele, K. D., and Matheson, N. H.: *Intra-abdominal Crises,* Washington, Butterworth, 1961.

Palmer, E. D.: *Diagnosis of Upper Gastrointestinal Hemorrhage,* Springfield, Charles C Thomas, 1960.

Wiener, A. S.: *Advances in Blood Grouping,* New York, Grune & Stratton, 1961.

### Dr. Spock Authors Pamphlet for Parents

Dr. Benjamin Spock, internationally-known pediatrician-author, has written "On Being a Parent—of a Handicapped Child," a new pamphlet in the Parents Series published by the National Society for Crippled Children and Adults. Copies are available at 25 cents from the Publications Service of the Society, 2023 West Ogden Avenue, Chicago 12.

## ★ Books

### Medical Discoveries: Who and When

J. E. SCHMIDT, Ph.B.S., M.D., Litt.D. 555 pages. $14.75. Springfield, Ill., Charles C Thomas, 1959.

The reviewer is honored to report on this book. It was started by the late James Coleman, M.D., past president of the Travis County Medical Society. He was a student of his specialty, with a hobby for medical history, and with an intense personal interest in the evaluation of each individual's contributions to medicine and to the community of his time.

The book is a compilation of more than 6,000 important contributions to medicine. Its entries are from medicine, dentistry, pharmacy, opticianry, midwifery, and physics. The basic formula of information is the name of the discoverer or inventor, nationality, occupation or profession, the dates of birth and death, and the date of discovery. Alphabetical order throughout the text makes the finding of information easy.

The work is too voluminous to try to cover it by generalizations, but mention of the contributions in a limited field may illustrate its usefulness. For example: "Thyroid deficiency is accompanied by reduced metabolic activity and that condition may be relieved by the administration of dessicated thyroid. Pub. 1895 by Adolph Magnus-Levy, German physiologist in the U. S. 1865-1955.

"George Redmayne Murray, English physician, 1865-1939, treated myxoedema by hypodermic injection of thyroid extract of a sheep with 'Highly Successful Results' pub. 1891.

"William W. Gull, English physician, 1816-1890, described the condition of myxoedema with atrophy of the thyroid gland in 1874. Known as Gull's Disease.

"Thomas Whatton, English anatomist, 1610-1673, introduced the term 'thyroid gland,' in 1656. Thyroid, organic iodine in (six important discoveries or observations are listed under the alphabetical section I and space does not permit their detailed accounting).

"Pierre Lalouette, French physician, 1711-1792, described an inconstant third lobe of the thyroid gland, arising usually on the left side. Published in 1743. Known as Lalouette's pyramid.

"Odilion Marc Lannelongue, French surgeon, 1840-1911, transplanted the thyroid gland from an animal to a human being, for the relief of cretinism. Recorded in 1890.

"J. Moritz Schiff, German physiologist, 1823-1896, reported in 1859, experimental thyroidectomies which proved fatal. Later, in 1884, Schiff followed his thyroidectomies with intra-abdominal transplantation of the gland, a procedure which saved the experimental animals.

"Joseph Henry Green, English surgeon, 1791-1863, is credited with performing the first recorded thyroidectomy on June 13, 1829. Green removed the right lobe of the gland; the patient died 15 days after the operation.

"Ludwig Rehn, German surgeon, 1849-1930, performed the first recorded operation for the removal of the thyroid in exophthalmic goiter in 1880, recorded in 1884.

"Herman Ludwig Blumgart, American physician, 1895- , with S. A. Levine and D. D. Berlin, treated congestive heart failure and angina pectoris by thyroidectomy. Recorded in 1933.

"Paul Sick, German surgeon, is credited with being the first to note and record symptoms following total thyroidectomy. Pub. in 1867.

"Bernhard Moritz Carl Ludwig Riedel, German surgeon, 1846-1916, described a form of chronic inflammation of the thyroid, in 1896. Known as Riedel's disease or struma.

"Charles Robert Harington, English biochemist, 1897- , determined the molecular structure of thyroxine. Pub. in 1926.

"Edward Calvin Kendall, American physiologist and chemist, 1886-19 , isolated crystalline thyroxine on Dec. 25, Christmas Day, in 1914.

"Charles Robert Harington, English biochemist, 1897- , demonstrated that thyroxine is a derivative of tyrosine. Pub. in 1926. Charles Robert Harington, English biochemist, 1897- , with George Barger synthesized thyroxine. Recorded in 1927. Unfortunately this does not cover all the contributions about the thyroid, some of which appear in other sections, but it does give some idea of the magnitude of this work."

Proper tribute should be paid to Dr. J. M. Coleman for his research in children's psychology with the University of Texas. The magnitude of his contributions to the community is appreciated by his colleagues, and those of us with kindred interests in the history of medicine will miss his warm, personal discussions.

—Joe C. Rude, M.D., Austin.

### Laboratory Tests in Common Use

SOLOMON GARB, M.D., Associate Professor of Pharmacology, Albany Medical College. 174 pages. $2.50. New York, Springer Publishing Company, Inc., 1959.

## Current Therapy—1960

Edited by HOWARD F. CONN, M.D., with the aid of 306 authorities selected by a special board of consultants. ed. 12. 808 pages. $12. Philadelphia, W. B. Saunders Company, 1960.

Dr. Conn picked 12 consulting editors, all outstanding specialists, who chose 306 authorities to write the individual articles.

This book is one that every doctor who treats patients should have. It is not only for the internist, but for the surgeon, obstetrician, and general practitioner. Inside the front and back covers is a list of normal laboratory values of clinical importance.

This is not just a new edition of the old book. Articles have been rewritten and some authorities have changed their subjects. As treatments have changed, new medications have been mentioned. It is particularly interesting to notice the treatment recomended in this new edition, then to refer to an earlier edition to see how the uses of different antibiotics have changed. New ones have been added, and as some of the organisms have become resistant to certain antibiotics, newer ones have had to be developed. In section 16, there is a roster of drugs. It gives additional information on the types of drugs, their uses, and how they are packaged. There is a pediatrics table of dosage, the usual conversion charts from the metric to the apothecary system, and charts for making percentage solutions. The book is well indexed. It keeps one posted on what is new and reaffirms the treatment that is still considered the best, regardless of the date of its origin.

This book should be in every practitioner's office. If the 1961 review is in the same class, it should be added to the practitioner's library as soon as it is available.

—John W. Tunnell, M.D., Taft.

## The Last Stitch

WILLIAM CROSTHWAIT and ERNEST FISCHER; Philadelphia and New York, J. B. Lippincott Company, $3.50. 1956.

Dr. W. L. Crosthwait, in his 56 years of medical practice, made a habit of jotting down notes. Out of these notes and his splendid memory grew a human story of a doctor's life and the practice of medicine in Texas. "I anticipated that the period from my first stitch to my last stitch would not be uneventful."

At the age of 83, Dr. Crosthwait recalls his teaching career while he earned money to study medicine. He cites his problems as medical director of the $50,000 Hearst Relief Fund following the Galveston hurricane in 1900, which he compared to the Waco Disaster in 1953. He describes the first use of typhoid prophylaxis in the Holland territory, his meeting with the Doctors Mayo, and subsequently his first thyroidectomy and his war service as a member of Dr. Cushing's team in the European area.

He was a member of the State Board of Examiners from 1903 to 1915, and served on the State Board of Health from 1917 to 1921. At this time he formed with Dr. Goddard and Pat Neff the Texas War Risk Society, which laid the foundation for the Veterans Hospital at Kerrville. Looking forward, Dr. Crosthwait hopes for the affinity of education, law, and medicine as a powerful force for good. He advocates that doctors take an active part in politics. He is a firm believer in organization, and is an active member of his county and state medical organizations, the Texas Surgical Society, and the American College of Surgeons.

## Lectures on the Interpretation Of Pain in Orthopedic Practice

ARTHUR STEINDLER, M.D.; (hon.) F.R.C.S. (Eng.); (hon.) F.R.S.M. (Eng.); F.A.C.S.; (hon.) F.I.C.S., Professor Emeritus, Orthopedic Surgery, State University of Iowa Medical School, Iowa City. 658 pages. $18.50. Springfield, Ill., Charles C Thomas, 1959.

In the practice of orthopedics, pain usually is an early and often the presenting symptom, and this premonitory pain may well be manifest during a stage of reversibility of the disease process. Doctor Steindler has called on his more than 40 years of experience to compile a detailed and comprehensive text on pain syndromes likely to be encountered by the orthopedist.

The author emphasizes that this work is not presented with the intention of basing a diagnosis on a single symptom, but rather with the hope that a better understanding of the pain syndromes will enable earlier diagnosis of the underlying disturbance. This point is accentuated throughout the text by a discussion of the underlying pathologic anatomy and physiology in conjunction with case reports on the clinical course and prognosis.

The author leaves few, if any, points undiscussed in regard to the etiology of pain in affectations of the neuromuscular and skeletal systems.

There is a tendency to slight during the physician's training and to neglect in practice the analysis and interpretation of pain. This text presents in a logical manner an abundance of information invaluable as a background for the wise practice of orthopedic surgery.

—Philip Overton, M.D., Dallas.

# RECENT DEATHS

## DR. PENN RIDDLE

Dr. Penn Riddle, 65, Dallas surgeon, died in that city on March 31, 1961.

Born in Granbury on February 8, 1896, Dr. Riddle was one of the nine children of the late Judge George W. Riddle and Rosa (Branderburg) Riddle. He received a bachelor of science degree from Texas Christian University, Fort Worth, and received his medical degree in 1919 from Baylor University College of Medicine, Dallas. He did nine months of postgraduate study at Harvard and three months at the University of Vienna, Austria. Dr. Riddle interned at Baylor Hospital, Dallas, and did his residency at Johnson and Bell Hospital, Fort Worth, and Boston City Hospital, Boston.

Dr. Riddle began practicing medicine in Dallas in 1922. About that time, he began teaching at Baylor University College of Medicine, retiring as assistant professor of clinical and operative surgery when the school was moved to Houston. Between 1935 and 1947, he was director of the varicose vein clinic at Parkland Hospital, and from 1925 to 1960 he was physician to federal prisoners in Dallas county. For 30 years, he was medical director for the Rio Grande National Life Insurance Company.

Dr. Riddle was author of a book, "Injection Treatment," published in 1940 by W. B. Saunders Company. He was a member of the American College of Surgeons, American Medical Association, Texas Medical Association, Dallas County Medical Society, Dallas Southern Clinical Society, and the Board of Life Insurance Medicine.

DR. PENN RIDDLE

In private life, Dr. Riddle was a student of finance and stocks, and he enjoyed doing amateur carpentry and electrical work. He was a past director of the Dallas Junior Chamber of Commerce, and he belonged to the Kessler Park Methodist Church.

The physician is survived by his wife, the former Katharine Harris, whom he married in Dallas in 1927; two daughters, Mrs. H. Grady Beaird of Lancaster, Calif., and Miss Celia Katharine Riddle of Dallas; three sisters, Mrs. Erwin Singleton of Beaumont, Mrs. Sim T. Lake of Dallas, and Mrs. John C. Coit of Dallas.

## DR. H. T. JACKSON

Dr. Holland Taylor Jackson, 51, who was named the Texas Medical Association's "General Practitioner of the Year" in 1956, died of a heart attack March 3, 1961, in Fort Worth.

Dr. Jackson was born in Copperas Cove on January 20, 1910, and graduated from Hico High School. In 1931 he received a bachelor of science degree from Trinity University.

As a 15 year old boy watching helplessly as his mother died of cancer, he vowed to become a physician. By taking on a series of jobs, including an 18 month stint in the oil fields, he financed his premedical and medical degrees, receiving the latter from the University of Texas Medical Branch, Galveston, in 1935. He interned at Detroit Receiving Hospital and Fort Worth Methodist (now Harris) Hospital.

In 1939, Dr. Jackson married the former Miss Clara Eugene Mercer, an obstetrics nurse supervisor at the Fort Worth hospital.

Dr. Jackson was one of a group of 15 physicians who made plans for organizing the American Academy of General Practice before it became a reality in 1947. He served on its first board of directors, was treasurer of the organization from 1952 to 1955, and became its president in 1958. It was through efforts such as his that continued education became a basic requirement for membership in the Academy.

As one of the first officers of the Texas Medical Association's Section on General Practice, Dr. Jackson served as its secretary and later as chairman. He held many committee appointments in the Tarrant County Medical Society and was its delegate for a number of years.

The preceptorship program at the University of

DR. HOLLAND T. JACKSON

DR. G. A. SCHENEWERK

Texas Medical Branch is largely a result of Dr. Jackson's efforts. He also helped to set up the department of general practice in Fort Worth's Harris Hospital and served on the staffs of all the Fort Worth hospitals.

The physician was a former member of the Tarrant County Medical Society and the Texas and American Medical Associations, and was a past president of the Texas Academy of General Practice. He was a Mason and a Shriner, and he belonged to the Broadway Baptist Church in Fort Worth. He was a member of the Fort Worth Chamber of Commerce and was a fancier of thoroughbred Dalmatian dogs.

Survivors include Mrs. Jackson; one son, Don Jackson, Texas Tech student at Lubbock; and two daughters, Brenda Jackson of Fort Worth and Martha Jackson, Texas Tech student at Lubbock.

## DR. G. A. SCHENEWERK

Dr. George August Schenewerk, 63, Dallas physician and former vice-president of the Texas Medical Association, died in his Dallas home March 14, 1961, following a heart attack.

Born in Anna, Collin County, on October 1, 1897, Dr. Schenewerk was the son of the late Mr. and Mrs. John F. Schenewerk. He was graduated from the old University of Dallas, then receiving his medical degree from Baylor University College of Medicine in 1921. He interned at Baylor Hospital and did his residency at St. Paul's Hospital, Dallas. Except for service in both world wars, he was in private practice in Dallas.

Dr. Schenewerk served as an Army private in World War I and volunteered for duty in World War II. He became chief of surgical service at the Boca Raton Army Air Base Hospital, Florida, in 1942 and was released from active duty in 1945 as a lieutenant colonel.

The physician was active in organized medicine, civic affairs, and church work. He was president of the Dallas County Medical Society, vice-president of the Texas Medical Association, and a member of the American Medical Association, Dallas Southern Clinical Society, American College of Surgeons, and Phi Rho Sigma. He was a delegate to the American Medical Association for 18 years and was a member of the World Medical Association.

Dr. Schenewerk was elected to the Dallas City Council from 1951 to 1953. He was lecturer at the Dallas Police Training School and a member of the Citizens Traffic Commission. An avid sports fan, he served as official physician for the Texas Boxing Commission of Dallas County. He was a Rotarian, a member of the Dallas Athletic Club, and a member of the Chaparral Club.

A member of Christ the King Catholic Church, Dr. Schenewerk was also a member of the men's club of that parish. He was past president of the Ancient Order of Hibernians and belonged to the Catholic Physicians Guild and the Dallas Council of the Knights of Columbus.

Surviving are his wife, the former Marie Busacker, whom he married in 1924; three daughters, Mesdames Ernest Fisk, James R. Pitts, and Michael Kurilecz, all of Dallas; two brothers, J. F. Schenewerk and Robert H. Schenewerk, both of Dallas; three sisters, Mrs. Don L. Chapman of Dallas, Mrs. John C. Koetting of Houston, and Mrs. Clarence F. Quinn of Texas City.

## DR. T. CLAYTON SHIRLEY

Dr. Thomas Clayton Shirley, 59, Tyler physician and surgeon, died of a heart attack in a Brady hospital January 30, 1961. He was under the care of a nephew, Dr. Albert McCulloh, at the time.

Dr. Shirley was born January 18, 1902, in Irene, Tex. He was the son of Mr. and Mrs. A. Shirley. Graduating from the University of Texas Medical Branch in 1927, he interned at John Sealy Hospital and at the Wichita Falls Clinic Hospital. In 1936 he studied in Vienna.

The physician had a private practice in Tyler from 1930 on. He was for many years a member of the American Medical Association and the Texas Medical Association, and he was a fellow of the American College of Surgeons. Dr. Shirley was president of the Smith County Medical Society in 1942. He belonged to the Elks and was a Shriner.

Survivors include his wife, the former Maymerle Batsell, whom he married in 1930; his mother, Mrs. A. Shirley of Gatesville; a son, Michael Shirley of New York City; two daughters, Mrs. Maymerle Brown and Miss Sandra Shirley, both of Tyler; a brother, Newton Shirley of Austin; two sisters, Mrs. Ida McCulloh of Penelope and Mrs. Pearl Dyess of Gatesville; and one grandson, Robert Y. Brown III of Tyler.

## DR. H. H. NIEHUSS

Dr. Henry Hosea Niehuss died at his home in Longview on January 12, 1961.

He was born in New Truxton, Mo., October 31, 1876, and was the son of Mr. and Mrs. Henry Christian Niehuss. He attended Wesleyan College in Warrenton, Mo., and was graduated from Sewanee University of the South, Sewanee, Tenn. Dr. Niehuss received his doctor of medicine degree from Memphis Hospital Medical College, Memphis, Tenn., in 1902. He practiced medicine in El Dorado, Ark., for 20 years, and was Union County health officer there. He was the editor of the Arkansas State Medical Journal from 1910 through 1912.

In 1933, Dr. Niehuss moved to Texas and practiced in Greggton and operated a hospital in Gladewater. In 1948, he moved to Longview, and was appointed city health officer, a position he held until shortly before his death.

He was elected to honorary membership in the Texas Medical Association in 1954; he was a member and past president of the Gregg County Medical Society and the Texas Geriatric Society. He was a Fellow of the American College of Surgeons, and a member of the American Medical Association. Dr. Niehuss also was medical director of the Southwest Reserve Life Insurance Company for 17 years, and he founded and was elected the first president of the Insurance Medical Directors of Texas.

He was a member and former president of the El Dorado and Gladewater Rotary Clubs, and was an honorary member of the Longview Rotary Club. He was an elder in the First Presbyterian Church of Longview.

Dr. Niehuss and Miss Martha Ann Kitchen were married in 1908.

Survivors include Mrs. Niehuss; a son, Henry Cortez Niehuss, Gurdon, Ark.; a daughter, Mrs. Frank Sporer, Van Alstyne; a brother, Martin Niehuss, Warrenton, Mo.; and four grandchildren.

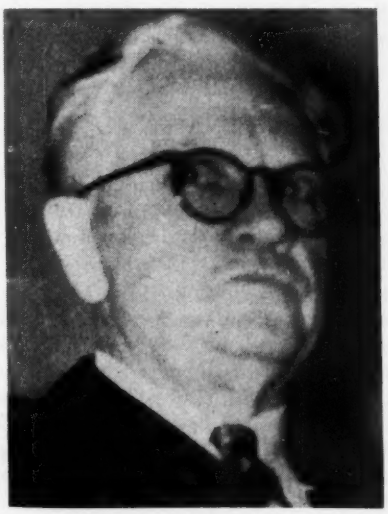
## DR. C. R. FINNEGAN

Dr. Charles Robert Finnegan, 69, Dallas general practitioner, died in that city on March 16, 1961, after a short illness.

Born in Ironton, Wisc., April 19, 1891, Dr. Finnegan was one of seven children, two of whom were to become physicians; two, dentists. He received his bachelor of arts degree from Ripon College, Ripon, Wisc. Two years of his medical education were spent at the University of Wisconsin, Madison, after which he attended the St. Louis University School of Medicine, St. Louis, Mo., graduating in 1919. He interned at Lutheran Hospital, St. Louis, and did postgraduate work in gynecology at Harvard.

Dr. Finnegan opened his practice in Dallas in 1923. At one time he served the city as assistant director of public health, and he was for many years on the active staff of St. Paul's Hospital. He was a member of the American Medical Association, the Texas Medical Association, and the Dallas County Medical Society. He belonged to Holy Trinity Catholic Church.

The physician was preceded in death by his wife,



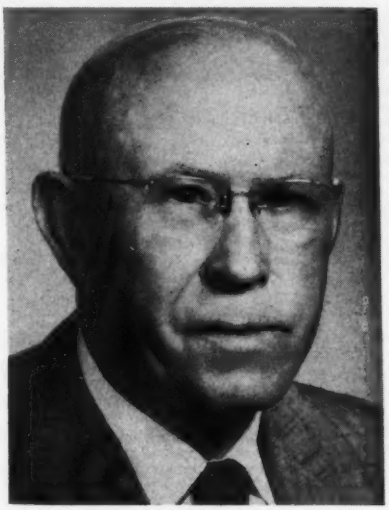
DR. C. R. FINNEGAN

who died in 1935. Surviving are his son, Charles R. Finnegan Jr., Dallas; a daughter, Sister Charles, D.C., Dallas; and a sister, Mrs. Catherine Bodentine of LaValle, Wisc.

## DR. C. W. JAMISON

Dr. Cyrus Walker Jamison, who had been associated with the Dallas Veterans Administration since 1945, died February 12, 1961, after a short illness.

Born April 19, 1882, in New Market, Iowa, he attended public schools and studied for three years at Keene Industrial College, Keene, Tex. He was awarded his medical degree from Baylor University College of Medicine in 1920; his education had been interrupted by military service in 1918.



DR. C. W. JAMISON

Dr. Jamison interned at Parkland Hospital, Dallas, and later did postgraduate work in Battle Creek, Mich. He began private practice in Dallas immediately and maintained his practice for 24 years before joining the staff of the Veterans Administration. He was a medical rating specialist at the time of his death.

Dr. Jamison was a member of the American Medical Association, Texas Medical Association, and Dallas County Medical Society. He belonged to the East Dallas Christian Church.

Extremely active in Masonic work, Dr. Jamison was past Master of Trinity Valley Lodge 1048 and a thirty-second degree Mason. He had served as Master of the Fourteenth Degree, Scottish Rite, since 1933. Past Master of Dallas Chapter Rose Croix, he was recognized by the Supreme Council, Thirty-third Degree, in 1951 by his investiture with the rank and decoration of Knight Commander of the Court of Honor. In addition, he was past High Priest of J. Lee Zumwalt Chapter 422, Royal Arch Masons, and past Commander of Dallas Commandery 6, Knights Templar. In 1959 he had the Order of High Priesthood conferred upon him by the Grand Council of Colorado.

Surviving Dr. Jamison are his wife, the former Miss Vesta Johnson, whom he married August 12, 1928, in Dallas; a sister, Mrs. Delia S. Mayer, San Bernardino, Calif.; and two brothers, G. J. Jamison, Napa, Calif., and Harry Jamison, Riverside, Calif.

## ★ Coming Meetings

American Medical Association, New York, June 25-30, 1961. Dr. F. J. L. Blasingame, 535 N. Dearborn, Chicago 10, Exec. Vice-Pres.

Texas Medical Association, Austin, May 12-15, 1962. C. L. Williston, 1801 N. Lamar, Austin, Exec. Sec.

### Current Meetings

MAY

American Gynecological Society, Colorado Springs, May 29-31, 1961. Dr. A. A. Marchetti, 3800 Reservoir Rd. N.W., Washington 7, D. C., Sec.

JUNE

American College of Chest Physicians, New York, June 22-26, 1961. Mr. M. Kornfeld, 112 E. Chestnut, Chicago 11, Exec. Dir.

American Dermatological Association, Tucker's Town, Bermuda, June 16-20, 1961. Dr. W. M. Sams, 308 Ingraham Bldg., Miami 32, Sec.

American Neurological Association, Atlantic City, June 12-14, 1961. Dr. M. D. Yahr, 710 W. 16th, New York 32, Sec.

American Proctologic Society, Pittsburgh, June 21-24, 1961. Dr. N. D. Nigro, 10 Peterboro, Detroit 1, Sec.

United States-Mexico Border Public Health Association, San Diego, June 25-29, 1961. Dr. U. Blanco, El Paso, Sec.

Texas State Board of Medical Examiners, Fort Worth, June 12-14, 1961. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Sec.

### National and Regional

American Academy of Allergy, Denver, Feb. 5-7, 1962. Mr. J. O. Kelley, 756 N. Milwaukee St., Milwaukee 2, Exec. Sec.

American Academy of Dermatology and Syphilology, Chicago, Dec. 2-7, 1961. Dr. R. R. Kierland, Mayo Clinic, Rochester, Sec.

American Academy of General Practice, Las Vegas, April 6-13, 1962. Mr. M. F. Cahal, Volker Blvd., at Brookside, Kansas City 12, Exec. Sec.

American Academy of Pediatrics, Chicago, Oct. 2-5, 1961; New York, April 30-May 2, 1962. Dr. E. H. Christopherson, 1801 Hinman, Evanston, Ill., Exec. Dir.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 8-13, 1961. Dr. W. L. Benedict, 15 2nd St. S.W., Rochester, Minn., Sec.

American Association of Genito-Urinary Surgeons. Dr. W. J. Engel, 2020 E. 93rd, Cleveland 6, Sec.

American Association of Obstetricians and Gynecologists. Dr. C. L. Randall, 216 Summer, Buffalo 22, Sec.

American Association of Plastic Surgeons. Dr. T. D. Cronin, 6615 Travis, Houston 25, Sec.

American Association for Maternal and Infant Health. Mrs. Patricia Dorr, 116 S. Michigan, Chicago 3, Exec. Dir.

American Association for Thoracic Surgery, St. Louis, April 16-18, 1962. Dr. H. T. Bahnson, Johns Hopkins Hosp., Baltimore 5, Sec.

American Cancer Society. Mr. G. Whittlesey, 521 W. 57th, New York 19, Sec.

American College of Allergists, Minneapolis, April 1-6, 1962. Mr. E. Bauers, 2160 Rand Tower, Minneapolis, Exec. Vice-Pres.

American College of Gastroenterology, Cleveland, Oct. 22-25, 1961. Mr. D. Weiss, 33 W. 60th, New York 23, Exec. Dir.
American College of Obstetricians and Gynecologists, Chicago, April 2-5, 1962. Mr. D. F. Richardson, 79 W. Monroe, Chicago 3, Exec. Sec.
American College of Physicians. Dr. E. C. Rosenow, Jr., 4200 Pine, Philadelphia 4, Exec. Dir.
American College of Radiology. Mr. W. C. Stronach, 20 N. Wacker, Chicago 6, Exec. Dir.
American Congress of Physical Medicine and Rehabilitation. Dorothea C. Augustin, 30 N. Michigan, Chicago 2, Exec. Sec.
American College of Surgeons, Chicago, Oct. 2-6, 1961. Dr. W. E. Adams, 950 E. 59th, Chicago, Sec.
American Heart Association, Miami Beach, Oct. 20-24, 1961. Mr. W. F. McGlone, 44 E. 23rd, New York 10, Sec.
American Hospital Association, Sept. 25-28, 1961. Dr. E. L. Crosby, 18 E. Division, Chicago, Exec. Dir.
American Public Health Association, Detroit, Nov. 13-17, 1961. Dr. B. F. Mattison, 1790 Broadway, New York 19, Exec. Sec.
American Society of Anesthesiologists, Los Angeles, Oct. 22-27, 1961. Dr. R. L. Patterson, 612 Bershire, Pittsburgh 15, Sec.
American Society of Clinical Pathologists, Seattle, Sept. 30-Oct. 8, 1961. Mr. Claude E. Wells, 445 Lake Shore Drive, Chicago 11, Exec. Sec.
American Surgical Association. Dr. W. Altemeier, Cincinnati General Hospital, Cincinnati 29, Sec.
Association of American Physicians and Surgeons, Inc., Asheville, N. C., Oct. 12-14, 1961. Mr. H. E. Northam, 185 N. Wabash, Chicago 1, Exec. Dir.
International College of Surgeons, U. S. Chapter. Dr. R. T. McIntire, 1516 Lake Shore Dr., Chicago, Exec. Dir.
Radiological Society of North America, Chicago, Nov. 26-Dec. 1, 1961. Dr. D. V. Needham, 713 E. Genesee, Syracuse 2, Sec.
South Central Association of Blood Banks, Fort Worth, 1962. L. R. Guy, Ph.D., 2927 Maple, Dallas 4, Sec.
Southern Medical Association, Dallas, Nov. 6-9, 1961. Mr. R. F. Butts, 2601 Highland, Birmingham 5, Exec. Sec.
Southern Psychiatric Association. Dr. R. Proctor, Winston-Salem, N. C., Sec.
Southern Surgical Association, Hot Springs, Va., Dec. 5-7, 1961. Dr. G. D. Lilly, 333 Ingraham Bldg., Miami 32, Sec.
Southwest Allergy Forum, April, 1962. Dr. H. E. Hawkins, 105 W. Elizabeth, Brownsville, Sec.
Southwest Regional Cancer Conference, Fort Worth, Sept. 24, 1961. Mrs. I. F. Ball, Westchester House, Fort Worth, Sec.
Southwestern Medical Association, Las Vegas, Oct. 19-21, 1961. Dr. M. Thomas, 1501 Arizona Bldg., El Paso, Sec.
Southwestern Society of Nuclear Medicine. Dr. J. R. Maxfield, Jr., 2711 Oak Lawn, Dallas, Sec.
Southwestern Surgical Congress, Albuquerque, N. Mex., April 2-5, 1962. Dr. R. B. Howard, 544 Pasteur Bldg., Oklahoma City 3, Okla.
Tri-State Medical Assembly. Dr. J. W. Wilson, Jr., 940 Margaret Place, Shreveport, Sec.

## State

Texas Academy of General Practice, Houston, Oct. 15-18, 1961. Mr. D. C. Jackson, 1905 N. Lamar, Austin, Exec. Sec.
Texas Academy of Internal Medicine, Houston, Dec. 2-3, 1961. Dr. S. C. Arnett, Jr., 2609 19th, Lubbock, Sec.
Texas Air-Medics Association, Austin, 1962. Dr. C. F. Miller, Box 1338, Waco, Sec.
Texas Association for Mental Health. Mrs. L. Marcus, 3525 Arrowhead, Dallas, Sec.
Texas Association of Obstetricians and Gynecologists, Dallas, February, 1962. Dr. H. W. Savage, 815 Fifth Ave., Ft. Worth, Sec.
Texas Association of Public Health Physicians. Dr. Elizabeth Gentry, 1313 Sabine, Austin, Sec.
Texas Chapter, American Academy of Pediatrics, Harlingen, Sept. 22, 1961. Dr. W. W. Kelton, Jr., 108 W. 30th, Austin, Sec.
Texas Chapter, American College of Chest Physicians, Austin, May 13, 1962. Dr. Donald L. Paulson, 3710 Swiss Ave., Dallas.
Texas Club of Internists. Dr. T. H. Harvill, Medical Arts Bldg., Dallas 1, Sec.
Texas Dermatological Society, Dallas, Nov. 5, 1961. Dr. D. S. Blair, 1609 Medical Arts Bldg., Dallas, Sec.
Texas Diabetes Association, Austin, May 13, 1962. Dr. John W. Chriss, 2436 Morgan, Corpus Christi, Sec.
Texas Division, American Cancer Society, Fort Worth, Dec. 7-8, 1961. Mr. C. W. Reimann, 5014 Bull Creek Rd., Austin 3, Exec. Sec.
Texas Heart Association. Mr. E. T. Guy, 404 Jesse H. Jones Library Bldg., Houston 25, Exec. Dir.
Texas Industrial Medical Association, Austin, May 13, 1962. Dr. R. E. Joyner, Box 471, Texas City, Sec.
Texas Neuropsychiatric Association. Dr. E. I. Bruce, Jr., 1014 Strand, Galveston, Sec.
Texas Ophthalmological Association, Austin, May 14-15, 1962. Dr. Harold Hunt, 150 Eighth St., S.E., Paris, Sec.
Texas Orthopedic Association, Austin, May 14, 1962. Dr. Margaret Watkins, 3503 Fairmount, Dallas, Sec.
Texas Otolaryngological Association. Dr. Louis E. Adin, Jr., 3707 Gaston, Dallas, Sec.
Texas Pediatric Society, Harlingen, Sept. 22-23, 1961. Dr. C. E. Gilmore, 811 Bonham, Paris, Sec.
Texas Physical Medicine and Rehabilitation Society. Dr. O. Selke, Medical Professional Bldg., Houston, Sec.
Texas Proctologic Society, February, 1962. Dr. T. Melton, 636 Hermann Professional Bldg., Houston, Sec.
Texas Public Health Association, Houston, Feb. 11-14, 1962. J. N. Murphy, Jr., P. O. Box 5192, Austin 31, Sec.
Texas Radiological Society, Austin, Jan. 19-20, 1962. Dr. R. P. O'Bannon, 1217 W. Cannon, Ft. Worth, Sec.
Texas Rheumatism Association, Houston, Dec. 1, 1961. Dr. J. Kemper, 6655 Travis, Houston, Sec.
Texas Society of Athletic Team Physicians, Austin, April, 1962. Dr. L. Levy, Ft. Worth, Sec.
Texas Society on Aging, San Antonio, Dec. 1-2, 1961. Mrs. W. B. Ruggles, 3701 Stratford, Dallas, Sec.
Texas Society of Gastroenterologists and Proctologists, Austin, May, 1962. Dr. Belton Griffin, 6648 Fannin, Houston, Sec.
Texas Society of Ophthalmology and Otolaryngology. Dr. O. Suehs, 14 Medical Arts Square, Austin, Sec.
Texas Society of Pathologists, Inc., Galveston, last week of Jan., 1962. Dr. V. A. Stembridge, Southwestern Medical School, Dallas, Sec.
Texas Society of Plastic Surgeons. Dr. R. O. Brauer, 6615 Travis, Houston, Sec.
Texas Surgical Society, Waco., Oct. 1-3, 1961. Dr. G. V. Brindley, Jr., Scott and White Clinic, Temple, Sec.
Texas Traumatic Surgical Society, Austin, May 13, 1962. Dr. J. C. Long, 805 W. 8th, Plainview, Sec.
Texas Tuberculosis Association, El Paso, March 29-31, 1962. Mrs. J. R. Walton, Jr., 1407 Andrews Hwy., Midland, Sec.
Texas Urological Society, Houston, February, 1962. Dr. N. F. McDonald, 915 Medical Arts Bldg., Houston 15, Sec.

## District

First District Society, Pecos, February, 1962. Dr. G. L. Black, 1501 Arizona, El Paso, Sec.
Second District Society. Dr. W. S. Parks, Jr., 2009 W. Wall, Midland, Sec.
Third District Society, Pampa, Sept., 1962. Dr. H. F. Johnson, 2308 W. 8th, Amarillo, Sec.
Fifth and Sixth Districts Society, Corpus Christi, July 8-9, 1961. Dr. J. Gabbard, 1001 Louisiana, Corpus Christi, Sec.
Seventh District Society. Dr. R. Lucas, 502 W. 13th, Austin, Sec.
Eighth District Society. Dr. J. L. Coleman, Box 3346, Victoria, Sec.
Ninth District Society.
Tenth District Society. Dr. I. M. Richman, 3280 Fannin, Beaumont, Sec.
Eleventh District Society. Dr. F. Verheyden, 813 John St., Jacksonville, Sec.
Twelfth District Society, Temple, Jan. 13, 1962. Dr. J. Dunlap, 2320 Columbus, Waco, Sec.
Thirteenth District Society. Dr. R. D. Moreton, 1217 W. Cannon, Ft. Worth, Sec.
Fourteenth District Society.
Fifteenth District Society. Dr. J. S. Leeves, Naples, Sec.

## Clinics

Blackford Memorial Cancer Lectures, Denison. Dr. A. O. Jensen, Suite N-1, Medical Center, Denison, Chm.
Dallas Southern Clinical Society Conference, Dallas, March 19-21, 1962. Dr. C. M. Cole, 1421 Medical Arts Bldg., Dallas, Sec.
International Medical Assembly of Southwest Texas, San Antonio, Jan. 29-31, 1962. S. E. Cockrell, Jr., 202 W. French Place, San Antonio, Exec. Sec.
New Orleans Graduate Medical Assembly. Mrs. Irma B. Sherwood, 430 Tulane Ave., New Orleans 12, Exec. Sec.
North Texas-Southern Oklahoma Fall Clinical Conference. Dr. F. J. Lee, 1300 8th, Wichita Falls, Chm.
Oklahoma City Clinical Conference, Oklahoma City, Oct. 23-25, 1961. Miss Alma F. O'Donnell, 503 Medical Arts Bldg., Oklahoma City 2, Exec. Sec.
Postgraduate Medical Assembly of South Texas, Houston, July 10-12, 1961. Mrs. W. H. Dahme, 412 Jesse H. Jones Library Bldg., Houston 25, Exec. Sec.
Private Clinics and Hospitals, Houston, Dec. 2-3, 1961. Mr. B. J. Warren, Deaton Hospital, Galena Park, Sec.

## Board Examinations

Texas State Board of Examiners in Basic Sciences, Austin, Mid-October, 1961. Mrs. Maria P. Hathaway, Exec. Sec., 1012 State Office Bldg., Austin.